La Fleur Weight Loss Program Intake Form

Patient Name: (Last) (First) (MI)

_____

Patient Address: _____ City: _____State: ___Zip:_____

Phone Number: _____Email: _____

Birthdate: _____Age: _____ Sex: M F

Occupation: _____

In Case of Emergency:

Name: _____ Relationship: _____

Phone: _____

How did you hear about us?

_____

Are you under the care of a qualified healthcare professional? Please list whom. *

_____

As detailed in the Consent portion, it is highly recommended that you are under the care of a qualified healthcare professional, who has verified that it is safe for you to exercise and be on a weight loss program and is monitoring medications and any health concerns that you list here (besides your weight issues- that's what we're covering). If you are on medications (particularly for high blood pressure, heart issues, or diabetes), you will need these to be monitored during and after the program as your need for them may change. *

I acknowledge the above statement above.

Sign: _____

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Medical History

Please list any medical conditions a medical provider has diagnosed you with in the past (such as high blood pressure, diabetes, arthritis, etc…): *

_____
_____
_____
_____

What medications, supplements and over the counter items do you take regularly or are currently prescribed: *

_____
_____
_____
_____

Any past surgeries and hospitalizations? *

_____
_____
_____

Please describe your family history in terms of heart disease, diabetes, obesity, high cholesterol, high blood pressure, and cancer:

_____
_____
_____
_____

Personal History

What are your main interests and hobbies?

_____

What is your line of work or study?

_____

Do you exercise regularly? Please detail.

_____

What kind of other movements or activities do you enjoy?

_____

You have problems falling or staying asleep?

_____

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How many hours do you sleep?

_____

Do you wake up refreshed?

_____

How is your energy?

_____

Does your energy level affect your daily activities?

_____

How would describe your mood, generally:

_____

Does your mood affect your life or daily activities?

_____

How would you describe your stress level?

_____

What are your sources of stress?

_____

How do you manage stress?

_____

Do you have people close to you who support you?

_____

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Diet and lifestyle

Do you regularly drink alcoholic beverages?

If yes, how many per week?

Do you smoke tobacco?

Do you use recreational drugs?

How is your appetite?

Snack Habits:

What:

_____

How much:

_____

When:

_____

Typical Breakfast:

What:

_____

How much:

_____

When:

_____

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Typical Lunch:

What:

_____

How much:

_____

When:

_____

Typical Dinner:

What:

_____

How much:

_____

When:

_____

How often do you eat out?

_____

What restaurants do you frequent?

_____

How often do you eat “fast foods”?

_____

Food allergies?

_____

Food dislikes?

_____

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Food cravings?

_____

Do you eat because of emotions (explain)?

_____

Do you drink coffee or tea? Yes No If Yes, how much daily?

_____

Do you drink pop / soft drinks? If yes, how much?

_____

Do you use sugar substitutes?

_____

What are your worst food habits?

_____

How much fluid do you normally drink? Please approximate in ounces.

_____

Please list all types of beverages you regularly drink.

_____

_____

Please list any food allergies, intolerances, or foods you avoid and the reason.

_____

_____

_____

What past struggles and difficulties have you experienced in terms of food and dieting?

_____

_____

_____

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What diet and exercise programs, protocols, plans or approaches have you tried in the past?

_____
_____
_____
_____

What types of diet and exercise approaches have worked for you in the past?

_____
_____
_____
_____

And what hasn't worked for you at all?

_____
_____
_____
_____

When did you first become overweight?

_____

How did your weight gain start? Describe any circumstances:

_____
_____
_____

What do you think is the cause of your weight problem?

_____
_____
_____

What was your highest weight? (Excluding pregnancy)

_____

What was your lowest weight?

_____

Have you ever stayed the same weight for 10 years or more?

_____

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How MOTIVATED are you to lose weight?

_____
_____
_____

Is there anything else you would like to tell us?

_____
_____
_____
_____

Please list the factors you feel have contributed to your current weight (check all that apply):

Slow metabolism	☐
Family history of obesity	☐
Comfort food dependency	☐
Lack of exercise	☐
Binge eating	☐
Late night snacking	☐
History of trauma	☐
History of grief and loss	☐
Medication related weight gain	☐
Significant restrictive eating behaviors like anorexia	☐

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Please answer the following questions to the best of your knowledge:

Health History *

	No, never	Yes, currently	Not currently, but within the last year	Not currently and longer than 1 year ago
Fatigue				
Unexplained weight loss or gain				
Change in appetite				
Depressive symptoms				
Anxiety				
Mood swings				
Nervousness				
Addictive dependency				
Disordered Eating Pattern/Tendency				
Tension				
Lack of mental focus				
Thyroid problems				
Diabetes				
Blood sugar irregularities				
Excessive thirst or hunger				
Sugar cravings				
Abnormal hair growth				

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Excessive perspiration				
Feeling excessively hot or cold				
Headache				
Lightheadedness				
Joint pain or stiffness				
Muscle weakness or soreness				
High blood pressure				
Heart murmur/palpitations				
Cold or pale extremities				
Asthma				
Short of breath				
Heartburn				
Abdominal discomfort after eating				
Nausea				
Abdominal bloating				
Belching/gas				
Constipation				
Diarrhea				
Daily bowel movements				

La Fleur Weight Loss Program Clinical Policies

PATIENT CONSENT FOR WEIGHT LOSS THERAPY AND TREATMENT WITH **La Fleur Weight Loss Clinic**

If you have any questions, please feel free to ask us.

Please initial each point acknowledging you understand that:

_____ If you are late or miss your appointment, you may be subject to a $50 fee.

_____Services must be paid for at the time of service.

_____Health insurance typically does not cover services provided at La Fleur Weight Loss Clinic. If you want to seek insurance reimbursement, we are unable to provide you with itemized invoices that you can submit to your insurance company.

_____Phentermine and Vyvanse are considered controlled substances. I agree that I will take my medications as prescribed. I agree to follow my medical provider's instructions. I also agree that I will not sell or share my prescriptions to other individuals.

_____I understand that treatments used at La Fleur Weight Loss Clinic might not be considered a medical necessity. Treatments rendered are for the purpose of improving your quality of life through hormone restoration, nutritional and supplemental counseling, and weight loss treatment.

_____ I agree that if I am having any side effects or become sick, that I will follow up with my primary care provider or go to an urgent care or emergency department.

_____I acknowledge that La Fleur Weight Loss Clinic and La Fleur Weight loss Clinic staff are not my primary care provider unless I elect them so. I agree that I will continue with routine care through my primary care provider and notify them of treatments prescribed at La Fleur Weight Loss Clinic

_____I understand that there are no refunds for services or products rendered. We cannot accept back used medications once they have been dispensed per state regulation.

_____I understand that having an appointment with La Fleur Weight Loss Clinic does not necessarily entitle me to being issued a prescription for hormone replacement, weight loss medication or additional medications. Every individual is different, and it is at the medical provider's discretion to issue a prescription.

_____I understand that I must maintain my follow up appointments to remain on treatment. It is important that lab work is monitored regularly for safety purposes. It is important that La Fleur Weight Loss Clinic Medical Provider manages my treatment, and it is at their discretion to provide.

La Fleur Weight Loss Program Clinical Policies

_____I acknowledge that I have been advised of the risks and benefits of treatment. I also acknowledge that I have been advised of possible complications and side effects. I understand the risks, benefits, complications, and side effects of treatment.

_____I am voluntarily requesting treatment with La Fleur Weight Loss Clinic regarding weight loss therapy as determined by a mutual decision between myself and the medical provider even if my hormone levels are considered to be in normal range for my age based off of other medical society recommendations and guidelines or if I am just considered overweight and not obese.

_____I do not hold any medical practitioner of La Fleur Weight Loss Clinic responsible for performing age-related preventive care. I agree that I will follow up with my primary care provider to obtain these screenings and I hold Thrive Weight Loss Clinic and Thrive Weight Loss Clinic Medical Providers harmless if an adverse event occurs during my treatment. I will ensure that my primary care provider provides the results of such screenings to Thrive Weight Loss Clinic as this could change the treatment prescribed to me.

I have read, understand, and agree with all the above statements.

Print Name: _____

Signature: _____Date_____

Indemnification Clause

I, _____, agree to indemnify, defend, protect, and hold harmless the medical providers employed by La Fleur Weight Loss Clinic and their respective officers, directors, employees, stockholders, assigns, successors and affiliates (Indemnified Parties) from, against and in respect of all liabilities, losses, claims, damages, judgements, settlement payments, deficiencies, penalties, fines, interest and costs, expenses suffered, sustained, incurred or paid by the indemnified parties, in connection with, results from or arising out of, directly or indirectly, the medical providers employed by La Fleur Weight Loss Clinic rendering medical care, services, advice, and/or treatment, my failure to disclose all relevant information regarding my medical and physical condition, acts or omissions, the medical providers employed La Fleur Weight Loss Clinic ;; harm or injury resulting from medical care or pharmaceuticals provided directly or indirectly by the medical providers employed by La Fleur Weight Loss Clinic;. I am aware of the potential side effects associated with BHRT and hormone replacement therapy provided by La Fleur Weight Loss Clinic accept all the risks involved with IV infusion and injectable therapies, and will not seek indemnification or damages from the indemnified parties.

Printed Name: _____

Signature: _____Date: _____

Witness: _____Date: _____

B12 Injections Informed Consent Patient

Name: _____

Vitamin B-12 helps maintain optimal health and has been shown to be beneficial in helping to reduce fatigue, improve memory, and maintain a healthy body weight. It is what your body uses to help create energy, which is one of the reasons people feel more energized when they take B12.

All medications and supplements have potential side effects, including B12. Most people tolerate B12 without issue, side effects are rare. Potential common B12 side effects include but are not limited to mild diarrhea, upset stomach, nausea, pain at the injection site, swelling, headache and joint pain.

You acknowledge:

1. That if I begin to have side effects, I will contact La Fleur Weight Loss Clinic immediately and notify them of what is happening.

2. I understand that although rare, vitamin B12 injections can result in serious side effects. If these occur, you should follow up with a medical provider or go to the emergency department immediately. Uncommon and dangerous side effects include: rapid heartbeat, chest pain, flushed face, muscle cramps, weakness, difficulty breathing and swallowing, dizziness, confusion, rapid weight gain, feeling of tightness in the chest, hives and rashes, shortness of breath when there is no physical exertion and unusual wheezing and coughing.

3. Before starting vitamin B12 injections I agree to make my La Fleur Weight Loss Clinic aware if I have any of these conditions: Leber's Disease, liver disease, kidney disease, iron deficiency, folic acid deficiency, receiving any treatment or taking any medication that influences bone marrow, or drug/supplement allergies.

4. I understand that there could be interactions with B12 and certain medications/supplements.

5. The use of B12 on a weekly to biweekly basis without a documented B12 deficiency is considered off label use and has not been FDA approved for increasing energy levels and weight loss.

6. Caution is advised while taking B12 if you have a sulfa allergy.

By signing below, I acknowledge that I have read the informed consent and agree to the treatment with its associated risks. I hereby give consent for B12 injections. I agree to inform my medical provider immediately if I have any side effects. I hereby release La Fleur Weight Loss Clinic and the person injecting the B12 of any damages or liability if anything was to occur.

Patient Signature_____ Date: _____