Cape Coral Weight Loss & Wellbeing

1407 Viscaya Pkwy. Suite 2
Cape Coral, FL 33990
t: (239)471-2183

Registration Form

(please print)

Today's Date: _____ Referred By: _____

PATIENT INFORMATION

Patient's name (last, first, middle) _____

Mr.____ Mrs.____ Miss____ Dr.____

Marital status: Single____ Married____ Divorced____ Sep____ Wid____

Date of Birth:_____ Sex: M____ F ____

Street Mailing Address:

_____

City: _____ State:____ Zip: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Occupation: _____

Email Address: _____

Primary Physician: _____

Chose clinic because/referred to clinic by: Doctor. ____ Current Client:____ Walk-In:____
Family Friend:____ Close to home/work:____ Internet:____ Other:_____
Other family members seen here: _____

IN CASE OF EMERGENCY:

Name of local friend or relative (not living at same address): _____
Relationship to patient: _____
Home/Cell phone_____ Work phone: _____

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance owed. I also authorize Cape Coral Weight Loss & Wellbeing to release any information required to process my claims.

Client Signature: _____ **Date:** _____

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your clinic record.

Name (Last, First, M.I.): _____ □ M □ F
DOB: _____ **AGE:**_____
Height: _____ **IDEAL WEIGHT GOAL:** _____ lbs
PHYSICIAN:_____ **LAST PHYSICAL EXAM:**_____

PERSONAL HEALTH HISTORY:
Childhood illness: □ Measles □ Mumps □ Rubella □ Chickenpox □ Rheumatic Fever □ Polio
Medical Problems: □ Gout □ Hypertension □ Hypothyroidism
□ Hx of Blood Clots □ Gallbladder □ Diabetes

List any other medical problems that other doctors have diagnosed:

_____
_____
_____
_____

Surgeries & Hospitalizations:
Year: _____ Reason: _____
Year: _____ Reason: _____
Year: _____ Reason: _____

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any Allergies to medications? ____ Yes ____ No
If so which drugs: _____

HEALTH HABITS AND PERSONAL SAFETY
Exercise: □ Sedentary (No exercise) □ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
□ Occasional vigorous exercise (i.e., work or recreation, less than 4x /week for 30 min.)
□ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet: Are you dieting? □ Yes □ No
If so which diet: _____
# of meals you eat in an average day? _____
Any Prior Diet Programs? □ Yes □ No If so which diets: _____
Caffeine: □ None □ Coffee □ Tea □ Cola (# of cups/cans per day? _____)

FAMILY HEALTH HISTORY
Mother's health concerns: 1._____ 2._____
3._____ 4._____
Father's health concerns: 1._____ 2._____
3._____ 4:_____

WOMEN ONLY
1. Date of last menstruation? _____ Period every _____ days
2. Heavy periods, irregularity, spotting, pain, or discharge? □ Yes □ No
3. Duration of Cycles _____ days

4. Are you pregnant or breastfeeding? □ Yes □ No
5. Have you had a hysterectomy, or are you post menopausal? □ Yes □ No
6. Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? □ Yes □ No
7. Experienced any recent breast tenderness, lumps, or nipple discharge? □ Yes □ No
8. Date of last pap and rectal exam?

MEN ONLY

1. Do you feel pain or burning with urination? □ Yes □ No
2. Any blood in your urine? □ Yes □ No
3. Have you had any kidney, bladder, or prostate infections within the last 12 months? □ Yes □ No
4. Do you have any problems emptying your bladder completely? □ Yes □ No
5. Any testicle pain or swelling? □ Yes □ No
6. Date of last prostate and rectal exam? □ Yes □ No

OTHER PROBLEMS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

□ Skin	□ Chest/Heart	□ inability to eat certain foods
□ Head/Neck	□ Back	□ Weight changes
□ Ears	□ Intestinal	□ decrease/increase in energy level
□ Nose	□ Bladder	□ problems sleeping
□ Throat	□ Bowel	□ Other pain/discomfort:
□ Lungs	□ Circulation	

Signature: _____ Date: _____

Cape Coral Weight Loss & Wellbeing
PATIENT CONTRACT

I,_____ , hereby commit to the suggested Cape Coral Weight Loss & Wellbeing protocol. I understand that if I do not adhere to the protocol, I may not achieve the desired or acceptable results.

I affirm that:
- I commit to strictly following this program for four weeks as directed without cheating.
- I commit to maintaining a daily food and exercise/activity diary.
- I commit to weigh myself daily on a digital scale and document it on my tracking sheet.
- I commit to visualizing myself at my ideal weight I am committed to my weight-loss goals.
- I commit to communicate with my weight loss advisor and inform her/him of my progress as requested.
- I commit to checking all spices and seasonings that I use for sugar content and substitute for sugar free versions & will remove all junk food, addictive foods, or foods I crave from my cabinets, refrigerator, freezer, and house.
- I commit to take responsibility for my own actions and know that Cape Coral Weight Loss & Wellbeing cannot control what I consume.
- I commit to eating two mini-meals a day and two snacks, and to stay away from breads, pasta, rice, sugar, sauce and fats. I understand that failure to do so may result in weight gain and program failure.
- I commit to eat only the allowed foods on the protocol & completing the stabilization & maintenance phases.
- I commit to saying to myself every day, "I forgive myself, accept myself, and love myself," even if I cheat or fall, I will get back up and accept the consequences ie.. weight loss may be affected for a week.

I understand that failure to comply may sabotage my weight-loss goals, and I could regain most if not all of the weight I lost back. I agree to adhere to all of the above commitments in order to achieve permanent weight loss.

How did you hear about us:

( ) your doctor	( ) facebook	( ) google	( ) bing
( ) a friend	( ) magazine	( ) website	( ) other _____
( ) radio	( ) newspaper	( ) TV	

Signature: _____

Date: _____

Weight Loss Consumer Bill of Rights

Florida Statute 501.0575 outlines the rights of consumers seeking professional weight-loss services. Please read these rights below.

A. Warning: rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1 ½ to 2 pounds per week or weight loss of more than 1% of body weight per week after the second week of participation in a weight loss program.
B. Consult your personal physician before starting any weight-loss program.
C. Only permanent lifestyle changes, such as making healthful food choices and increasing physical activity, promote long-term weight loss.
D. Qualifications of this provider are available upon request.
E. You have a right to:

1. Ask questions about the potential health risks of this program and its nutritional content, psychological support and educational components.

2. Receive an itemized statement of the actual or estimated price of the weight loss program, including extra products, services, supplements, examinations, and laboratory tests.

3. Know the actual or estimated duration of the program.

4. Know the name, address, and qualifications of the physical, dietician or nutritionist who has reviewed and approved the weight-loss program according to Section 468.505(1)(i) of the Florida Statutes.

Informed Consent

Please carefully read the following statements, and please sign below indicating your understanding and agreement.
A. My Responsibilities: I understand that it is my responsibility to follow my advisors instructions carefully and to report any medical problems immediately. I am currently not pregnant and agree to report any pregnancy to my physician immediately.
B. Risks of Proposed Treatment: The use of appetite suppressants poses various risks, including by not limited to, pulmonary hypertension, nervousness, sleeplessness, headaches, dry mouth, allergies, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could occasionally be serious or even fatal.
C. Risks Associated With Being Overweight or Obese: I understand that remaining overweight poses certain risks, among them high blood pressure, diabetes, heart disease, arthritis at the joints, and certain cancers. I understand that these risks may be modest if I am not very overweight, but that these risks increase significantly with any weight gain.
D. No Guarantees: I understand that much of the success of this program will depend on my efforts. I understand that there are no guarantees or assurances that the program will be successful. I also understand that I will have to continue watching my weight all my life if I am to be successful. I will not sue or hold Cape Coral Weight Loss & Wellbeing and/or any employees responsible/accountable for problems or contraindications for anything whatsoever.
E. Duplicate Medications: I understand under Florida regulations, duplicate controlled medications cannot be obtained from another doctor.
F. Patient's Consent: I have read and fully understand this consent form, the attached Florida Weight Loss Consumers Bill of Rights, and I have had all concerns addressed by weight loss advisor.

Patient's Signature: _____ Date: _____

Patient's printed name: _____