PERSONAL DATA SHEET

Weight Loss

Patient's Name _____ Date_____

Address _____City_____ State____Zip_____

Date of Birth _____ Home Phone _____Work Phone _____

Cell Phone _____ Fax_____ email address_____

Your Employer_____Address_____

Occupation _____ Marital Status S M W D Separated

Spouse's Name _____ Occupation_____

How were you referred to this office? _____

One person to contact in case of an emergency:

1. Name_____ Address_____ Phone_____

Do you have any other health complaints? (Please list) _____

_____

_____

Health History

Are you being treated for any medical conditions? ____ Please describe _____

_____

_____

Please list surgical operations you have had/or planning to have and dates: _____

_____

_____

Please check drugs you now take: __ Nerve pills __ Pain pills __ "Pep" pills __ Muscle relaxers __ Other

Have you ever had an injury or accident? __ Never __ Past year __ Past 5 years __ Over 5 years

Describe previous injury or accident _____

_____

_____

Family Health Information **(please list any conditions, diseases, etc of family members)**

Name	Relationship	Past and Present Health Problems	Approx Weight

(Please Complete Both Sides)

Do you believe that you are overweight? Yes ___ No ___

Please rate on a scale of 1-10 (with 10 being the greatest) _____

What do you believe to be the cause? _____

_____

What have you tried in the past to lose weight? _____

_____

Have you ever been successful in losing the weight? Yes____ No____ Please explain_____

_____

Did you regain the weight and if so, how much? _____

Why do you believe you have regained the weight? _____

_____

How would you describe your emotions about your weight? _____

_____

How would you rate your desire to lose weight on a scale of 1 to 10? (with 10 being the greatest) _____

I realize this is a scientific program of body compartment (i.e., fat, muscle, water) evaluation that will identify why I have gained weight and I understand that current laboratory testing will be necessary to rule out other causes of weight gain. I agree that I will notify the doctor's office immediately of any difficulty or problems that might arise during treatment with this office.

Under no circumstances will I instruct, inform, or teach anyone how to do this program. I realize that all written and verbal information regarding this program is confidential between the doctor's office and me.

I also agree that if for any reason I discontinue periodic monitoring by the doctor, I will immediately stop the diet program if I have not been placed on the maintenance eating plan by the doctor.

_____ _____

Signature Date

_____

Please Print Name

*Please read and sign the Consent to Treat form

**Please read and sign the HIPAA Compliance Statement