SHOALS
FAMILY CLINIC

Medical History

Name: _____

DOB: _____ Date: _____

Phone number: _____ Home/Cell

Address: _____

_____

Allergies: _____

_____

Email address (to access patient portal): _____

Who is your primary care provider? _____

Please list any other physicians you see _____

_____

Preferred Pharmacy: _____

How did you hear about us?: ____ Billboard _____ Radio _____Friend _____ Other: _____

_____

Current Medications: _____

_____

_____

_____

Social History: Smoking ____ Vape ____ Smokeless Tobacco ____

Personal History:

__ Anemia
__ Allergies
__ Asthma
__ Cancer
__ Diabetes
__ Eczema
__ Heart Disease
__ Hepatitis
__ High Cholesterol
__ High Blood Pressure
__ HIV
__ Migraines
__ Peptic Ulcers
__ Psychiatric Disorders
__ Seizures
__ Stroke
__ Substance Abuse
__ Thyroid Disorder
__ Abnormal Menstruation
__ Sleep Apnea

Other: _____

_____

Family History:

__ Cancer
__ Diabetes
__ Heart Disease
__ Stroke
__ Thyroid Disorder
__ Psychiatric Disorder
_____ Other _____
_____
_____

Surgical History (list):

_____

_____

_____

Please provide date of your last exam (month/year):

Eye Exam _____
Prostate Exam/PSA _____
Mammogram _____
Colonoscopy _____
Foot Exam _____
Pap Smear _____

Last Menstrual Period: _____

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Shoals Family Clinic to use and disclose my protected health information to perform treatment, payment and operations of healthcare. The Notice of Privacy Practices provided by Shoals Family Clinic describes such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Shoals Family Clinic reserves the right to revise its notice of privacy at any time and may be obtained by written request.

With this consent, Shoals Family Clinic, may call my residence and speak to me or leave a message via test or voice and/or mail to my residence regarding any items that may assist the practice with healthcare operations such as appointment reminders, insurance, patient statements, lab/test results and any items pertaining to my clinical care. I also understand that Shoals Family Clinic uses electronic health records. By signing this form, I am consenting Shoals Family Clinic to use and disclose my protected health information to perform healthcare operations. I may revoke my consent in writing except to the intent that the practice has already made disclosures in reliance to my prior consent.

Patient's Representative/Patient's Signature _____

Date _____

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Consent for Treatment

Name: _____ DOB: _____ Date: _____

I, the undersigned, hereby voluntarily consent to outpatient care at Shoals Family Clinic encompassing routine diagnostic procedures, examinations and medical treatment including but not limited to routine laboratory work, radiological studies, referrals to specialists and administration of medications prescribed by the provider. I further consent to the performance of those items listed above by the staff and assistants.

Deductibles/Percentage Pays/Co-Payments/Self Pay

Co-payments are due at the time of service. Deductibles and percentage payment amounts will be billed at the time payment is received from the Insurance Company. Payment is due within 30 days of invoice from the Billing Department. Self-Pay patients are required to pay the office visit and any additional costs (injections, testing, etc) at time of service. Any questions regarding billing should be directed to the biller.

Cancellations/Late Arrivals

Cancellations should be made greater than 24 hours before appointment time unless extenuating circumstances. Being more than 15 minutes late for an appointment may necessitate rescheduling your appointment.

Patient's Representative/Patient's Signature_____

Date : _____

Relationship to Patient : _____

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Weight History

Name: _____ Date: _____

DOB:_____ Gender: M___F ___ Age _____

What is your approximate weight? _____ pounds What is your height? _____ ft _____ inches

How old were you when you first became more than 20 pounds overweight? _____

What was your weight in high school? _____lbs Were you overweight as a child? Yes ____ No _____

What was the highest weight you have been in your life? _____ pounds

Have any of your close relatives been overweight or had obesity? Mother _____ Father _____ Siblings _____ (check all that apply)

Weight Management History

Have you ever been treated by a doctor for your weight? If so, when? Yes _____ No _____ _____ (yr)

Were you successful? Yes _____ No _____ How much weight did you lose? _____ lbs

Please indicate which of the following programs you have tried:

Program	Length of time	Weight Lost	When
NutriSystem			
Optavia			
Weight Watchers			
Other			
Other			

Weight History

To the best of your recollection, indicate your lowest (L) and highest (H) weight during each time interval

Write down anything you remember that might have contributed to your weight gain or weight loss.

Age	Lowest	Highest	Contributing factors
10-19			
20-29			
30-39			
40-49			
50-59			
60-69			
70-79			

Have you ever taken medication to lose weight? Check all that apply

Phentermine (e.g., Adipex) _____ Contrave (naltrexone/ bupropion) _____

Qsymia (phentermine/ topiramate) _____ Belviq (lorcaserin) _____

Saxenda (liraglutide for weight loss) _____ Xenical (prescription orlistat) _____

Alli (over the counter orlistat) _____ Topamax (topiramate) _____

Glucophage (metformin) _____ Ozempic (semaglutide) _____

Rybelsus (semaglutide) _____ Mounjaro (tirzepatide) _____

Wegovy (semaglutide) _____ Other _____

Other _____

Surgery

Have you ever had bariatric surgery? Yes _____ No _____

Are you currently interested in considering bariatric surgery? Yes _____ No _____

Have you ever consulted a surgeon regarding bariatric surgery? Yes _____ No ____

Social Support

Does your family support your efforts to have a healthier lifestyle? Yes _____ No _____

Do you see a counselor of any kind (e.g., therapist, religious leader, addiction counselor, psychologist, psychiatrist)? Yes _____ No _____

Do you belong to any support groups (e.g., Weight Watchers, Overeaters Anonymous, Alcoholics Anonymous, Alanon, etc.)? Yes _____ No _____

Dietary Habits Please describe your most common habits for each category. Enter 0 if you do not eat that meal or snack.

Meal/Snack	Time of Day	Place (home, restaurant, car, etc)/Typical Foods
Breakfast		
Morning Snack		
Lunch		
Afternoon Snack		
Dinner		
Evening Snack		
Late Night Snack		
Grazing		

During the last 3 months, did you have any episodes of excessive overeating (i.e., eating significantly more than what most people would eat in a similar period of time)? Yes _____ No _____

If yes, about how many times? _____

Do you sometimes make yourself vomit as a means to control your weight? Yes _____ No _____

Have you ever been diagnosed with (check all that apply): Binge eating disorder _____ Anorexia nervosa _____ Bulimia _____

Physical Activity

Do you exercise regularly? Yes _____ No _____

If "yes," what kind of exercise? _____

How many times per week? _____ How many minutes per session? _____

How many hours per day do you watch television? _____

What is your average screen time each week (social media, Kindle, etc)? _____

Do you work outside the home? Yes _____ No _____

If yes, what type of work? _____

Do you do housework? Yes _____ No _____ How often? _____

Feelings About Eating and General Mood

Do you feel distressed about episodes of overeating? Yes _____ No _____

Do you often feel like you have no control over your eating or that you are unable to stop eating?

Yes _____ No _____

Are you often embarrassed by how much you eat? Yes _____ No _____

Do you frequently feel disgusted with yourself for overeating or do you feel guilty for overeating?

Yes _____ No _____

Check the answer that best describes your feelings:

	Always	Frequently	Occasionally	Rarely	Never
I have little interest or take little pleasure in doing things.					
I feel down, depressed, or hopeless.					
I have trouble falling or staying asleep.					
I sleep too much.					
I feel tired or have little energy.					
I have a poor appetite because of my mood.					
I overeat because of my mood.					
I feel bad about myself. I feel like a failure and/or I have a lot of guilt.					
I have trouble concentrating on things or making decisions.					
I move or speak slowly in a way that other people notice.					
I'm restless and feel like I have to keep moving.					
I think about hurting myself or that I would be better off dead.					
How difficult have these symptoms made it for you to do your work, take care of things at home, or get along with other people?					

What are your weight loss goals? _____

_____

_____

_____

_____

What do you think are barriers to reaching your goal? _____

_____

_____

_____

Are You Ready For Change?
Test Your Readiness

This fast and easy quiz can help you assess whether you're ready for change.

1. Which of the following is your first thought when contemplating changing the types of foods that you eat?
   A. I really dread making this change. I enjoy the foods that I normally eat.
   B. I am slightly anxious about it. I will find it difficult, but I think that I can do it.
   C. I am fine with the idea of changing my diet. I am even looking forward to it a little bit.

2. How necessary do you think that it is for you to make some lifestyle changes?
   A. I do not think that it is all that important. I think that the media overemphasizes the importance of these things.
   B. I do think that it is important, but it is not one of my most pressing priorities.
   C. I know that it is extremely important right now. I am willing to make it a priority.

3. The idea of preparing home-cooked meals from fresh food makes me feel:
   A. Overwhelmed and unhappy. I do not have the time or desire to do this.
   B. OK, but I am used to eating a good many convenience and restaurant meals.
   C. Good. I am looking forward to trying new recipes and techniques.

4. Exercise is:
   A. Torture for me. It is boring, and/or I do not have time for it, and/or I just do not enjoy doing it.
   B. OK, but I would rather do other things.
   C. Important for my health. I think I will find it fun once I figure out something that I like. I am committed to it.

5. Why are you thinking of making these lifestyle changes?
   A. To get other people off of my back. I am sick and tired of hearing about it. Personally, I do not think it really matters whether or not I do this.
   B. Mainly for my appearance and/or so that other people will approve of me.
   C. I am doing it for my health, my self-esteem, my appearance, and myself.

6. How do you plan on attacking the challenge of changing your lifestyle?
   A. I am just going to keep trying things and hopefully something will work.
   B. I am going to change several specific things at one time. I am just going to wake up on the designated day and start my new life.
   C. I have chosen a few important steps. I am going to incorporate them into my life one at a time, and then I will move onto the next.