SERENE BOLD HEALTH CLINIC LLC
4606 FM 1960 W, Ste 224, Houston TX, 77069
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Phone: 281-944-5692
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Patient Name_____ DOB_____

Describe my current weight

I am…	Married	Never Married	Divorced	Widow/ Widower	Other:	
# of Children…	0	1	2	3	4	Other: ____
I live at home with…	Name: Age:	Name: Age:	Name: Age:	Name: Age:	Name(s): Age(s):	
The town/city I live in is…						
For a living I... (occupation)						
At this time, my exercise routine includes…	Activity:	Minutes:	Times/ week:			
My Current Stress level is…	None	Low	Medium	High		
My biggest stressor is…	Job	Relationship	Health	Other:		
My tobacco use is…	Current	Former	Never	Quitting		
My current alcohol use is...	None	Occasional	Weekly	Daily	A Problem	
My current recreational substance use is…	None	Type:	Frequency:			
My current TV/computer time per week is…	Less than 7hrs	7 to 15 hrs.	Over 15 hrs.			
I have had a problem with drug or alcohol addiction in past…	No	Yes	Which?			

My **Most Important Reasons** for wanting to *Change* my weight:

I decided to come to Serene Bold Health Clinic to help me with my weight because:
_____

My weight at age 20 was _____ lb.
My Weight one year ago was:_____ lb.
The MOST I ever weighed (non-pregnant) was_____ lb.
I began to gain weight because: _____
My **worst** food habit is_____

I am a **stress** eater	Yes	No	
I eat in the middle of the night	Yes	No	
My significant other has a weight issue	Yes	No	N/A

Patient Name_____

During the last 3 months, I have had episodes of excessive overeating where I ate more than what most people would eat in a similar period of time: Yes No

- *If "No" go to **Beverage** box below*
- *If "Yes" complete the following:*

During these episodes I feel I have NO CONTROL over my eating Yes No
I eat during these episodes even when I am not hungry Yes No
During these episodes I feel embarrassed by how much I ate Yes No
During these episodes I feel disgusted with myself, or guilty afterward Yes No
In the past 3 months, I have sometimes made myself vomit to try to control my weight Yes No

BEVERAGE: I **drink** the following routinely (circle all that apply):

Beverage	Number per Week
Fruit Juice	
Sweetened Tea	
Sports Drinks	
Energy Drinks	
Regular Soda	
Diet Soda	

Typical Meals for me include: (if "none", please note that)

Breakfast	Lunch	Supper	Snacks

I have done the following **weight loss programs** before:

Program	Year	Result

I have used weight loss medication before: No Yes If yes, which? _____

I am currently using weight loss products: No Yes If yes, which? _____

The person(s) closest to me support my intentions to do this program: No Yes Unsure

Long term, I would like to maintain my weight at _____lbs.

I would like to be at my goal weight in _____ months

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CONSENT FOR WEIGHT LOSS PROGRAM

I, _____, authorize Serene Bold Health Clinic associated health care providers, to help me in my weight-reduction efforts. I understand that my program may consist of a balanced-deficit diet, a regular exercise program, instruction on behavior modification techniques, and may involve the use of anti-obesity medications. Other treatment options may include a very low-calorie diet or a protein-supplemented diet. I further understand that if medications are used, they have been used safely and successfully in private medical practices with experienced obesity medicine specialists as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with having excess weight or obesity. Risks of this program are usually temporary, reversible, and may include but are not limited to nervousness, sleeplessness, headaches, electrolyte abnormalities, dry mouth, gastrointestinal disturbances, weakness, fatigue, pancreatitis, psychological problems, gallstones, high blood pressure, rapid or slowing of the heartbeat and heart irregularities, and risk of weight regain. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints, including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight but will increase with additional weight gain over time.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees that the program will be successful. I also understand that obesity is a chronic, lifelong condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and it has been fully explained to me. My questions have been answered to my complete satisfaction.

_____ _____
Patient's Name (printed) Witness

_____ _____
Patient Signature Date
(or signature of person with authority to consent for patient)