Jones Family Practice
1118 W Broadway St
Muskogee, OK 74401 * 918.912.5372

Welcome to **Jones Family Practice**

We're so glad to have you join us today! Date: ______________________________

CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL INFO

Name____

Address____

Date of Birth ____________________ Sex ____________ Race______________________

Phone ____________________ Email ____

Emergency Contact Name & Phone Number: _______________________________________

How were you referred to us? ____

MEDICAL HISTORY

Are you currently under the care of a physician? YES / NO

If yes, for what? ____

Primary Care Physician: ___________________________ Phone: __________________

Do you have any of the following medical conditions? (Please mark YES or NO to all)

PLEASE CHECK ALL THAT APPLY	YES	NO		YES	NO
CANCER			DIABETES		
HIGH BLOOD PRESSURE			HERPES (HSV-1 ORAL OR HSV-2 GENITAL)		
ARTHRITIS			HEADACHES/MIGRAINES		
HIV/AIDS			CONSTIPATION		
SKIN DISEASE			SERIOUS INJURIES		
SEIZURE DISORDER			RECENT SURGERIES		

HORMONE IMBALANCE			THYROID IMBALANCES		
BLOOD CLOTTING ABNORMALITIES			ACTIVE INFECTION		
HEART CONDITIONS			STROKE		
PREGNANT OR TRYING			HEART ATTACK		
CONTRACEPTIVE USAGE			BREASTFEEDING		
NEUROLOGIC DISEASE			PARKINSON'S		
IRRITABLE BOWEL SYNDROME			HIGH CHOLESTEROL		
CROHN'S DISEASE			ARRHYTHMIA		
EATING DISORDER			AUTOIMMUNE DISEASE		
DEPRESSION			ANXIETY		

Is there a personal or family history of MTC and/or Multiple Endocrine Neoplasia syndrome type 2? YES / NO

What oral prescription medications are you presently taking?

____

____

____

What vitamins are you presently taking? ____

Are you presently taking any of the following medications or supplements listed below? (within the last 48 hours)

	YES	NO		YES	NO		YES	NO
ASPIRIN			GLUCOMANNAN			ORLISTAT / ALLI		
MOOD ALTERING MEDICATION			CONJUGATED LINOLEIC ACID (CLA)			RASPBERRY KETONES		
ANTI-DEPRESSANTS			7-KETO-DHEA					
BLOOD THINNERS			GREEN TEA EXTRACT					
HORMONES			GREEN COFFEE BEAN EXTRACT					

CHITOSAN			HYDROXYCUT					
CHROMIUM PICOLINATE			CAFFEINE					

Do you have any allergies? YES / NO

If yes, list: ____

NUTRITIONAL INFORMATION

Present Weight: _______________ Height:_____________ Desired Weight:____________

When would you like to be at your desired weight? _________________________________

Why do you want to lose weight? (Health Benefit, Appearance, etc.) ____________________

____

When did you begin gaining weight? Why? _______________________________________

____

What has been your maximum weight (non-pregnant) & when? _________________________

Have you tried other weight-loss programs? YES / NO

If yes, which ones: ____

Were you successful with it / were you able to keep the weight off? YES / NO

If yes, please explain: ____

Is your spouse, fiance, or partner overweight? YES / NO

How often do you eat out? ____

What restaurants do you frequent? ____

How often do you eat “fast foods”? ____

Food allergies? ____

Food dislikes? ________________________ Food cravings? _________________________

Do you eat because of emotions? Explain: ____ Do you eat more when there is an increase in stress? Explain: __________________________

Do you drink coffee or tea? YES / NO

If yes, how much daily? _____________________

Do you drink soft drinks? YES / NO

If yes, how much daily? _____________________

Do you drink alcohol? YES / NO

If yes, how much daily? ______________________

Do you follow any diets? YES / NO

If yes, what are they? ____

What are your worst food habits? ____

Typical Snacks: ____

Typical Breakfast: ____

Typical Lunch: ____

Typical Dinner: ____ Describe

your energy level:

- ______ Inactive
- ______ Light Activity
- ______ Moderate Activity
- ______ Heavy Activity
- ______ Vigorous Activity

On a scale of 1 to 10 with 10 being the MOST committed, how committed are you to taking acting and making a change in your life today? 1 2 3 4 5 6 7 8 9 10

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature ____ Date ______________________

Authorization & Notice of Privacy Practices

I understand that my private healthcare information is protected under HIPPA Privacy Regulations. I fully understand that my signature is consent and authorization to be examined by the medical team. I understand that my entire patient history will remain completely confidential and will not be released without express written consent from me.

____

Patient Signature

____

Print Name & Date

Weight Loss Consent Form

I, ________________________________, understand that: Each patient responds differently to medicine and may respond differently from one treatment to the next. As with all medicines, results are temporary and regular dosing is necessary. The length of time the injectable medication lasts varies in each patient. NO guarantee can be made with regard to the results and length of time it lasts.

There are some risks with any treatment. The following is the list of possible risk with injections:

- Pain or bruising, redness, bleeding at the injection site (these are usually minimal and dissipate in minimal amount of time)
- Some people may experience allergic reaction to the injections
- Stomach upset, diarrhea, constipation, and vomiting are possible side effects - Weight loss can be inconsistent from one week to the next.

I had been given the opportunity to have all of my questions answered. I will inform my practitioner of any changes in my medical history, current medications, and/or any changes relevant to this procedure prior to any further treatments.

I, ________________________________, have read and understand the ingredients of the injections being administered to me and I consent to treatment. I further acknowledge that I am taking this injection(s) of my own accord. I agree to release the facility and the medical practitioner from any liability arising from the procedure.

________________________________ ________________________________

Signature Print

____

Date