ASPEN CLINIC MEDICAL WEIGHT LOSS– PATIENT INFORMATION FORM

copy of driver's license or form of ID

Patient Name:_______________________________________

Date of Birth: _____________ **Age:** ______ **Sex:** M / F

Address:____

City: ___________________ **State:** _____ **ZIP:** __________

Phone: _________________(Cell) _________________ (Home)

May we **call** you? YES ☐ NO ☐ May we **text** you? YES / NO ☐

Email address: ____

Can we email you? YES ☐ NO ☐

How did you hear about us? (PLEASE CIRCLE) **TV** ☐ **RADIO** ☐ **WEBSITE/ONLINE** ☐ **SOCIAL MEDIA** ☐ **OTHER** ☐

FAMILY/FRIEND/CO-WORKER, IF SO, WHO REFERRED YOU?: ________________________________

BELOW TO BE COMPLETED BY ASPEN CLINIC STAFF

PLAN_______-_______CALORIES ______G PROTEIN **MEDICAL / ALL NATURAL / INJECTIONS**

Notes: ____ **CLASS:**_____________________

Date	Weight	BLOOD PRESSURE	PMP Clear?	Doctor Comments

ASPEN CLINIC - MEDICAL HISTORY FORM

THIS IS A MEDICAL HISTORY RECORD AND WILL NOT BE RELEASED TO ANY PERSON UNLESS WE ARE AUTHORIZED TO DO SO.

NAME:_____AGE:_____

OCCUPATION_____

DATE OF LAST PHYSICAL EXAM: _____

ANY ABNORMAL RESULTS/FINDINGS? YES/NO IF YES PLEASE LIST_____

_____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE)					
HIGH BLOOD PRESSURE	YES	NO	ASTHMA	YES	NO
HEART DISEASE/ATTACK	YES	NO	CANCER	YES	NO
DIABETES	YES	NO	SLEEP APNEA	YES	NO
THYROID DISEASE	YES	NO	DEPRESSION	YES	NO
GLAUCOMA	YES	NO	BULIMIA/ANOREXIA	YES	NO
MITRAL VALVE PROLAPSE	YES	NO	STROKE	YES	NO

LIST OTHER DIAGNOSIS/ILLNESS:

_____

PLEASE LIST ANY PAST AND IMPENDING SURGERIES AND DATES: _____

_____

_____

IS THERE A HISTORY OF ANY OF THE FOLLOWING IN YOUR IMMEDIATE FAMILY?					
HEART DISEASE/ATTACK	YES	NO	STROKE	YES	NO
DIABETES	YES	NO	HIGH CHOLESTEROL	YES	NO
HIGH BLOOD PRESSURE	YES	NO	OBESITY	YES	NO

LIST ALL MEDICATIONS/VITAMINS/HERBAL REMEDIES & DOSES YOU ARE CURRENTLY TAKING:

_____

_____

DO YOU HAVE ALLERGIES TO ANY DRUGS/MEDICATIONS AND LIST REACTIONS: YES/NO PLEASE LIST:

_____

HAVE YOU EVER BEEN TREATED FOR DRUG ABUSE? YES/NO

DO YOU DRINK ALCOHOL? YES/NO IF YES HOW MUCH AND HOW OFTEN DO YOU DRINK? _____

DO YOU SMOKE? YES/NO ARE YOU PREGNANT? YES/NO ARE YOU NURSING? YES/NO

*** I HEREBY ACKNOWLEDGE THAT ALL THE INFORMATION I HAVE LISTED IS TRUE:**

SIGNATURE: _____ DATE: _____

_____ _____

ASPEN CLINIC – REVIEW OF SYSTEMS FORM

PLEASE CIRCLE BELOW IF YOU HAVE ANY OF THESE SYMPTOMS:

EYES AND VISION	Yes	No
Eye disease	Yes	No
Blurry vision	Yes	No
Glaucoma		
EAR, NOSE, THROAT	Yes	No
Hearing loss	Yes	No
Sinus problems	Yes	No
Nose bleeds	Yes	No
Swollen glands in neck		
HEART & CARDIOVASCULAR	Yes	No
Heart trouble	Yes	No
Chest Pains	Yes	No
Sudden heart beat changes	Yes	No
Swelling of feet, ankles, hands		
RESPIRATORY	Yes	No
Frequent coughing	Yes	No
Spitting up blood	Yes	No
Shortness of breath	Yes	No
Asthma or wheezing		
GASTROINTESTINAL	Yes	No
Loss of appetite	Yes	No
Nausea or vomiting	Yes	No
Frequent diarrhea	Yes	No
Constipation	Yes	No
Blood in stool	Yes	No
Stomach pain		
GENITOURINARY	Yes	No
Frequent urination	Yes	No
Burning or painful urination	Yes	No
Blood in urine	Yes	No
Kidney stones	Yes	No
Irregular periods (females)	Yes	No
Vaginal discharge (females)		

MUSCULOSKELETAL		
Joint pain	Yes	No
Joint swelling	Yes	No
Muscle pain or cramps	Yes	No
Difficulty in walking	Yes	No
SKIN		
Rash or itching	Yes	No
Change in skin color	Yes	No
Change in hair or nails	Yes	No
Varicose veins	Yes	No
NEUROLOGICAL		
Headaches	Yes	No
Light headed or dizzy	Yes	No
Convulsions or seizures	Yes	No
Numbness or tingling	Yes	No
Tremors	Yes	No
Paralysis	Yes	No
Stroke	Yes	No
Head injury	Yes	No
ENDOCRINE		
Gland or hormone problem	Yes	No
Thyroid disease	Yes	No
Diabetes	Yes	No
HEMATOLOGIC/LYMPHATIC		
Slow to heal after cuts	Yes	No
Easily bruise or bleed	Yes	No
Anemia	Yes	No
Phlebitis	Yes	No
Transfusion	Yes	No
Swollen lymph glands	Yes	No

If yes was circled, please list the estimated date and frequency of occurrence:

_____

_____

_____

Patient Signature: _____ **Physician Signature:_____**

Date: _____

_____

_____

ASPEN CLINIC - CONSENT FOR MEDICAL WEIGHT LOSS TREATMENT FORM

I, _____, (patient or guardian) do hereby authorize the physicians of the Aspen Clinic, Inc. to assist me in weight reduction. I fully understand that this program shall consist of a reduction in caloric intake, regular exercise and behavioral lifestyle changes and that my treatment may include the use of appetite suppressants and other supplements. I further understand that in order to continue to receive appetite suppressants, I must show continued weight loss.

Regarding the use of appetite suppressants, I understand that there are potential risks involved. Reported side effects include nervousness, constipation, sleeplessness, headaches, dry mouth, weakness, tiredness, medication allergy, high blood pressure, rapid heartbeat and heart irregularities. I understand that these and other risks could, on occasion, be serious and possibly permanently disabling. _____*initial* I understand that if I develop side effects from the medication, I will discontinue taking the medication and notify the Aspen Clinic staff, as well as my primary care physician, immediately and in the event the problem is severe, I will go to the nearest Emergency room for immediate care. I do not have a history of alcohol abuse, drug abuse, schizophrenia, manic-depressive illness, or eating disorder, since these conditions constitute a contraindication to the use of appetite suppressants. _____*initial* I agree not to take any other weight loss medications, other than those prescribed by the physicians of the Aspen Clinic and further agree to inform the Aspen Clinic staff of ANY changes in my medication or medical history. _____*initial*

I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an exchange eating program without the use of appetite suppressants would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

I understand the risk associated with being overweight/obese, which include the possibility of death, high blood pressure, diabetes, heart attack and heart disease, stroke, arthritis of the joints, hips, knees and feet, and gallbladder disease. I also understand that rapid weight loss programs may increase the incidence of symptomatic gallbladder disease. _____*initial*

I understand that Bariatric Physicians have found appetite suppressants helpful for periods longer than those suggested in the medication labeling, and at times in larger doses than those suggested in the labeling. The physicians of the Aspen Clinic are not required to use the medications as the labeling suggests, but do use it as a source of information along with their own experience, the experiences of their colleagues, recent studies and recommendations of investigators. Based on these, they may choose, when indicated, to use the appetite suppressants for longer periods of times and in increased doses. As a patient of the Aspen Clinic, I understand that I may be prescribed medications as stated above. _____*initial*

There is no guarantee that this program will work for me. I understand that I must follow the program as directed, in order to achieve weight loss. By consenting to treatment, I agree to pay, in full, for all visits and charges incurred at each visit. I understand that these charges may or may not be covered by insurance and Aspen Clinic does not provide or fill out claim forms for insurance purposes. I also understand that no refunds are given out.

By signing below I certify that I have read and fully understand this consent form and understand the risks associated with my treatment for weight loss.

Patient:_____ Date:_____

Witness:_____

ASPEN CLINIC – WL/WG HISTORY, HIPPAA CONSENT, CX/RX POLICY FORM

Patient Name:_____

WEIGHT LOSS/GAIN HISTORY

Have you tried losing weight on your own without medication? **Yes / No**

Please list any diets/exercise plans you have tried or trying:_____

Are you currently getting treatment for obesity from another Physician? Yes / No Is the Physician using medication? ☐ **Yes / No** ☐
List medicine:_____

Have you taken appetite suppressants before? Yes / No How long ago? _____ Was it successful? **Yes / No** Please list any side effects you experienced: _____

Do you exercise regularly? Yes / No How many days per week?_____ What prohibits you from exercise?_____

☐ ☐

HIPPAA PATIENT CONSENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996(HIPPA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow- up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent. I understand that my medical or personal information will never be conveyed to parties outside myself without consent.

***Patient Signature*:_____ Date:_____**

CANCELLATION POLICY

Aspen Clinic implemented a cancellation policy which enables us to better utilize available appointments for patients, as well as decrease the waiting time. **If you are unable to keep your appointment, we ask for you to notify us at least 24 hrs in advance, or we will charge a non-cancellation fee of $25.00 for time reserved if you do not show or call to cancel/ reschedule 24 hrs in advanced.**

I am aware of the cancellation policy. ***Patient Signature*: _____ Date:_____**

_____ _____

PRESCRIPTION POLICY

Due to the controlled nature of the medication, please be aware that lost, stolen, or misplaced prescriptions cannot be replaced or written again within a 28 day period of being originally written. Also, there is no guarantee that you will be prescribed medication, this is solely determined by the doctor and their review of your medical history and what is best for your health.

I am aware of the prescription policy. ***Patient Signature*: _____ Date:_____**

_____ _____

ASPEN CLINIC - LIFESTYLE HISTORY FORM

Please answer the following questions as accurately as possible. The information will be used by our nutrition professionals to tailor our program to meet your individual needs.

When did you first begin to have concerns about your weight? _____

What is the primary reason for your wanting to lose weight? _____

If you are in a relationship/marriage – How would you rate your partner's eating habits? (Poor) 1 2 3 4 5 (Ideal)

Select TWO reasons that you feel are most responsible for your weight:

☐ Genetics ☐ People Around You No Time Because: ☐ Work ☐ Children ☐ Traveling

☐ Lack of Knowledge About Nutrition/Exercise ☐ Social/Environmental Events (stress, depression, etc)

☐ Age ☐ Health Related Issue; if so: _____

Have you tried dieting in the past? ☐ Yes ☐ No If yes, please use the area below for the 3 most recent -

Type (Low Carb, Liquid, Low Fat, etc)	Weight Change	Reason(s) For Discontinuing Diet
_____	_____	_____
_____	_____	_____
_____	_____	_____

On any past diets, was there anything in particular that you liked and/or disliked? If so, explain: _____

_____

Favorite food _____ Favorite drink _____

List TWO things you crave regularly _____

What is the one specific food/drink/snack/etc that is your "weakness"? _____

In a typical DAY - How many *meals* do you eat? ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

Please Check ALL that apply:

☐ Fast Food ☐ Take Out/Dine In ☐ Cook At Home ☐ DIET Soda ☐ Regular Soda

☐ Coffee ☐ Dessert/Sweets ☐ Eat at a Dining Room Table ☐ Watch TV While Eating

Do you exercise regularly? Yes☐ No☐

If yes - What do you do?_____ How Often?_____

Do you have any medical/health-related restrictions that affect your ability to exercise? Yes____ No____

If yes - please explain: _____

If you had to name one thing that you feel could help YOU the most in achieving your weight loss goals, what would it be?

_____

Patient Signature: _____ Date: _____

ASPEN CLINIC: Intramuscular Injections – PROVIDED PATIENT INFORMATION

B12 Facts

Vitamin B12 shots are most effective when taken at regular intervals (usually weekly or monthly). The body's ability to absorb vitamin B12 is reduced with increasing age. Older people are often detected to have a more potent vitamin B12 deficiency, even in cases where they do not suffer from pernicious anemia. Methylcobalamin (Methyl B12) is a unique form of vitamin B12, which is more readily converted into the coenzyme forms than conventional cyanocobalamin.

Benefits of B12

- Escalates metabolism, thereby aiding in weight loss
- Healthier immune systems
- Improves sleep without making you drowsy
- Increases energy, mental awareness and alertness
- Reduces allergies
- Helps the body to prevent stress, tension and anxiety
- Fights depression
- Improves mood stabilization
- Surges stamina for everyday tasks
- Lessens frequency/severity of migraines/ headaches
- Helps lower homocysteine levels in the blood, thereby reducing the probability of heart diseases and strokes

Payment Consent: I understand that Aspen Clinic Inc is a 'cash practice'; therefore, my insurance will not necessarily cover any procedure or payment toward any of my sessions. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I further agree in the event of nonpayment, to bear the cost of collection, and/or Court cost and reasonable legal fees, should this be required.

I have read the above information and clearly understand the purpose and risks of B12 and Lipotropic injections.

I agree to the payment terms and costs of the injections and procedures.

Patient Signature: _____ **Date:** _____

INFORMED CONSENT FOR TREATMENT

Purpose: This informed consent form is intended to 1) give fair notice of the requirements of patients seeking to participate in the vitamin injectables offered as a part of a weight loss program at Aspen Clinic Inc, 2) fully disclose some of the risks associated with participation in the injections available at the Aspen Clinic, and 3) obtain a written "Informed Consent" from the patient to undergo treatment by healthcare practitioners and employees associated with Aspen Clinic Inc.

A vitamin B12 shot is safe and generally has no negative side effects, even in higher doses. Some redness and/or swelling at the injection site may occur as with any injection. This should start to get better within forty-eight (48) hours. In rare cases, B12 can cause diarrhea, peripheral vascular thrombosis, itching, rash, hives, a feeling, or a sense, of being swollen over the entire body, headache and joint pain. Also, any vitamin allergy to any component of the injectables can cause an allergic reaction.

I acknowledge that no guarantee or assurance has been given by anyone as to the results which may be obtained. Each patient will respond differently and no guarantees of effectiveness, satisfaction, or duration of effect have or can be made. I UNDERSTAND AND ACKNOWLEDGE THAT PAYMENTS FOR THE ABOVE PROCEDURE ARE NON-REFUNDABLE REGARDLESS OF THE RESULTS.

I have read the information regarding risks and benefits of B12 and I understand the possible complications of injection therapy. I also understand the Aspen Clinic staff will not provide Medical Advice. I understand the benefits and risks of this shot. I hereby release my Employer, Aspen Clinic Inc, all Aspen Clinic associated staff, and any other organizations associated with this immunization, their affiliated, associated and related entities, and the directors, officers, employees, successors and assigns of all such persons and entity from any and all liability arising from or in any connection with this Vitamin B12 injection. I am in good health and/or I have my physician's approval. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand, the above paragraphs, and that I have had sufficient opportunity for discussion and to ask questions, and all of my questions have been answered to my satisfaction. I believe that I have adequate knowledge upon which to give any information consent to the proposed treatment. I consent to having injections today and for all subsequent treatments.

Patient Name (PRINT): _____ **Date:** _____

Patient Signature: _____ **Witness:** _____