R&K WELLNESS CLINIC, INC.

105 SAINT STEPHENS COURT
TYRONE,GA. 30290

Patient Information Form

Name: (Last)_____(First)_____(MI)___

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____Alternate Phone: _____

Email: _____

Birth Date: _____ _____

Age: _____ Sex: M F

Employer: _____ Occupation: _____

Work Phone: _____

How did you learn about us? (Please choose one)

1. Referral (name) _____

2. Noticed Sign [ ] Walk-in [ ] Flyer [ ] Other_____

3. Google [ ] Yahoo [ ] Other site _____

If found on the internet, what words or phrases did you search for? _____

In Case of Emergency:

Name: _____Relationship: _____ Phone: _____

Patient's Spouse: _____ Phone: _____

Family Physician: _____ Phone: _____

Financial Policy:

Thank you for selecting R&K Wellness Clinic for your needs. We are honored to be of service to you. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made.

I have read and understand all of the above and have agreed to these statements.

_____ _____

Patient's Signature **Date**

PRESCRIPTION MEDICATIONS:

Medication Name	Dose & Frequency	Approx. Start Time

MEDICATION ALLERGIES

Name of Medications	Reaction

SUPPLEMENTS & OVER THE COUNTER MEDICATIONS

Supplement / Medication Name	Dose & Frequency	Approx. Start Date

Patient History Form

Date: _____

Please complete this form to the best of your ability. The doctor will review your answers during your visit.

Last Name	First	Middle	DOB	Age	Sex

Primary Care Doctor	Office Number	Last Physical Exam

Height	Weight	(For weight loss patients) Goal Weight	Lowest Adult Weight (after age 18)

Main Reason for Visit	Referred by

Medical History	Y/N	For: Yrs/Mo.	**Medical History**	Y/N	For: Yrs/Mo
High Blood Pressure			Dementia		
Heart Attack/Stents			GERD/Ulcers		
Diabetes Mellitus			Palpitations		
High Cholesterol			Migraines/Headaches		
Arthritis			Seizures		
History of stroke			Glaucoma		
Low/High Thyroid			Insomnia		
Sleep Apnea			Atrial Fibrillation		
Obesity			Congestive Heart Failure		
Depressed			Cancer of _____		
Anxiety			Gallbladder Stones		
COPD/Emphysema			Colitis		
Low Back Pain			Gout		
Eating Disorder			Osteoporosis		
Hepatitis _____			Chronic Kidney Disease		

SURGERIES & HOSPITALIZATIONS

Reason/Diagnosis	Year
Tonsillectomy	
Cholecystectomy	
Appendectomy	
Hysterectomy / Partial / Total	
Joint Replacement Knee /Hip/Shoulder	
Heart Stent	
Heart Bypass	
Cesarean Section	
Pacemaker/Defibrillator	
Spinal Fusion	

OB/GYN HISTORY (Female patients)

Last Menstrual Period: Age at first onset of period:
If still menstruating: cycle _____ days Circle if (+): Heavy periods, irregularity, spotting or pain
Are you pregnant: NO YES Are you breastfeeding: NO YES Are you trying for a pregnancy: NO YES
Number of pregnancies: Abortions: _____ Living children (Vaginal _____ C-Section _____) Miscarriages _____
History of Sexual Abuse: NO YES

SPECIALISTS (If any)

SCREENING TEST HISTORY (Please check all that apply provide date and provider name)

		Date	Date	Date	Provider Name
	Endoscopy				
	Colonoscopy				
	EKG				
	Stress Test: Regular | Nuclear				
	Holter Monitor				
	Cardiac Cath				
	Echo Cardiogram				
	Carotid/Ultrasound				
	Abdominal Aortic Aneurysm				
	U/S Doppler Lower Legs				
	Mammogram				
	Pap Smear				
	Bone Density DXA				
	Microalbumin				
	PFT's				
	Memory Test				
	IOP				
	NCV				
	Metabolic Testing				
	ABP				
	Sleep Apnea Test				
	Flu				
	Pneumonia				
	Shingles				
	Tetanus				
	BioZ				
	Hormone Consent				
	Testosterone				
	PT/INR				
	Annual Physical				

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Eating Habits
(Please be as honest as possible so that we may better help you)

Breakfast

Do you have breakfast every morning? __ Yes __ Sometimes __ Never
Approximate time: _____
Examples:

_____

_____

Do you have a snack before lunch? __ Yes __ Sometimes __ Never
Approximate time: _____
Examples:

_____

_____

Lunch

Do you have lunch every day? __ Yes __ Sometimes __ Never
Approximate time: _____
Examples:

_____

_____

Do you have a snack before dinner? __ Yes __ Sometimes __ Never
Approximate time: _____
Examples:

_____

_____

Dinner

Do you have dinner every day? __ Yes __ Sometimes __ Never
Approximate time: _____
Examples:

_____

_____

Do you have a snack at night? __ Yes __ Sometimes __ Never
Approximate time: _____
Examples:

_____

_____

Any Alcohol Intakes: _____

NUTRITION EVALUATION

Vegetable Intake (pls. circle): <10% 20-40% 41-60% >60%
Number of meals per day:
Snacks per day: What snacks & when?
Food Allergies:
Food Dislikes:
Food(s) you crave: Any specific time of day/month you crave food?
Do you awaken hungry during the night? If yes, what do you do? YES NO
Behavior style (check only one): ____ Always calm & easy going ____ Usually calm & easygoing ____ Sometimes calm with frequent impatience ____ Seldom calm & persistently driving for advancement ____ Never calm & have overwhelming ambition ____ Hard-driving and can relax

	NO	YES		NO	YES	If not you, whom?
Partner or spouse overweight?			I plan my meals			
By how much lbs.			I cook my meals			
I eat out daily			I shop for food			
I eat out _____ times/week			I use shopping list for grocery			
I eat "fast foods" daily			Time of day I usually shop:			
I eat "fast foods" ____ times/week			I use sugar substitute			Which?
I drink cola drinks			I use butter			
I eat when I'm stressed			I use margarine			
I am currently stressed			I drink coffee or tea. How many cups? day:			
I skip meals			I eat on behalf of someone else			

If Weight Loss is an aim for you, please answer the following questions?
Goal Weight: In what time frame would you like to be at your goal weight:
Birth Weight: Weight one year ago:
Highest weight (non-pregnant) and when: Lowest Adult Weight (>age 18):
Main reason for your decision to lose Weight
When did you begin gaining excess weight? (Give reasons, if known):

Previous Diets followed	Approximate date & results of weight loss

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Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

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Weight Loss Program Consent Form

I _____ authorize **DR. Willaims/R&K Wellness Clinic** and whomever they designate as their assistants, 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 in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices 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 remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to 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.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long 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 I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Date: _____ **Time:** _____

Witness: _____ **Patient:** _____

(Or person with authority to consent for patient)

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Patient Informed Consent for Appetite Suppressants

I. Procedure and Alternatives:

1. I, _____ (patient or patient's guardian) authorize DR. Willaims/R&K Wellness Clinic to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to, the use of appetite suppressants for more than 12 weeks and when indicated in higher doses than the dose indicated in the appetite suppressant labeling.

2. *I have read and understand my doctor's statements that follow:*

"Medications, including the appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter term studies (up to 12 weeks) using the dosages indicated in the labeling.

"As a Bariatric physician, I have found the appetite suppressants helpful for periods far in excess of 12 weeks, and at times in larger doses than those suggested in the labeling. As a physician, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer term studies and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants *for longer periods of time and at times, in increased doses.*

"Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects (as noted below).

"As a Bariatric physician, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant use for longer periods of time and when indicated in increased doses. However, you must decide if you are willing to accept the risks of side effects, even if they might be serious, for the possible help the appetite suppressants use in this manner may give."

3. *I understand it is my responsibility to follow the instructions carefully* and to report to the doctor treating me for my weight any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.

4. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.

5. 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 the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

II. Risks of Proposed Treatment:

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks and in higher doses than the dose indicated in the labeling involves some risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness,

tiredness, psychological problems, medication allergies, high blood pressure, rapid heartbeat and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

III. Risks Associated with Being Overweight or Obese:

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am.

IV. No Guarantees:

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that I will have to continue watching my weight all of my life if I am to be successful.

V. Patient's Consent:

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

WARNING

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK YOUR DOCTOR NOW BEFORE SIGNING THIS CONSENT FORM.

DATE: _____ **TIME:** _____

PATIENT: _____ **WITNESS:** _____

(Or person with authority to consent for patient)

VI. PHYSICIAN DECLARATION:

I have explained the contents of this document to the patient and have answered all the patient's related questions, and, to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies and the risks of continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving the appetite suppressants in the manner indicated above.

_____

Physician's Signature

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12 Reasons
"Why I Want to Reach My Goal Weight"

Name: _____ **Date:** _____

Before writing your reasons down, give them some thought. It is important that these 12 reasons be true personal goals and desires. They should not be generalizations or what you think would please others because they will be used as your "personal motivator."

Take a few moments from time to time each day to thoughtfully read through this list. This is called mental programming. The original of your 12 reasons list is retained in your medical file. You will be given a copy to carry at all times. We suggest that you also transfer your list onto a 3 x 5 card which may be more convenient.

Make a promise to yourself now: "I will read the entire card whenever I am confronted with a difficult food situation." Reading the list will clearly reinforce your personal commitment to take control of your health and self-esteem.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9 _____
10. _____
11. _____
12. _____