CompleteClinics
Medical Wellness and Weight Loss

WELCOME

Date: ____________________ Birth date: _______________Age: _____Height______

Name: ____(Single Married Divorced Other)
LAST FIRST MI *Please circle one*

Street Address: ____

City: __________________________State:______________ Zip:__________________

Phone: (Home) (_____) ________-_________ / (Cell) (_____)_______-__________

Appointment Reminder (√) ONE Option: _____**TEXT** _____**EMAIL** ______**VOICE CALL**

E-mail:__________________________________Occupation:____________________

Parent or Guardian Signature (if patient is a minor):____________________________

Place of Employment:_________________________ Work #: (_____) ______-_______

Primary Doctor: ______________________________Phone: (_____) ______-_______

Cardiologist (If applicable): _____________________Phone: (_____) ______-_______

Endocrinologist (If applicable):___________________Phone: (_____) ______-_______

OBGYN (If applicable):_________________________ Phone: (_____) ______-_______

****May we contact your doctors to keep them updated on your progress in the program?**

________**YES** _______**NO**

How did you hear about us? (Please check one) ______Patient/Doctor Referral ______Internet ______Radio/TV ______Newspaper ______TV ______ Groupon / Living Social / Media Site ______Other

If Patient/Doctor Referral; Please give name: ______________________________________

Race/Ethnicity:

______ American Indian	______ Alaska Native
______ Black or African American	______ Native Hawaiian
______ Other Pacific Islander	______ White/Caucasian
______ Asian	______ Latino / Hispanic
_____ Declined to state	

CONTROLLED MEDICATION INFORMATION AND CONSENT

HYDROXOCOBALAMIN / CYANOCOBALAMIN / LIPO LEAN / METHYLCOBALAMIN SUB-Q INJECTIONS

I understand that this consultation with the clinician is strictly for use of B12 injections and not a consultation for the weight loss program with Complete Clinics. I fully understand that I may not qualify to utilize vitamin B12 subcutaneous injections due to the following (if applicable):

- If I have been found to have a vitamin B12 allergy.
- If I have been diagnosed previously to have an elevated vitamin B12 level.
- If I have the inability to tolerate subcutaneous injections for any reason.
- I understand that utilizing B12 injections may not lead directly to weight loss when used on its own.

ANORECTICES (PHENTERMINE, PHENDIMETRAZINE)

These are a class of medications which help to suppress the appetite and are generally associated with weight loss. These medications are indicated in the management of exogenous obesity as an adjunct in a regimen of weight reduction based on caloric restriction. These are medications that enhance weight loss by suppressing appetite and increasing metabolism. These medications are used as an aid to your weight loss.

DO NOT RELY ON THEM TOO HEAVILY!
YOU WILL NOT BE SUCCESSFUL IF YOU DO.

All of the medications that we use have been proven to be both safe and effective. We do prescribe appetite suppressants that are new to the market; however, their long-term effects are largely unknown. The class of medication, which suppresses the appetite through dopamine/nor epinephrine, has proven to be effective and limited side effects are predictable, manageable and reversible.

PHENTERMINE comes in various strengths and is dispensed as a tablet or capsule. There are both time-released and short acting formulations. The medication that is prescribed for you will take into account many different factors which the doctor will evaluate. Phentermine is slowly eliminated from the body, usually clearing the body within 4 to 5 days. Side effects include dryness of the mouth, agitation, headaches, irritability, heart palpitations and insomnia. Contraindications include untreated systemic hypertension, heart disease, glaucoma, bipolar depression, psychosis, hyperthyroidism, drug or alcohol abuse and pregnancy.

PHENDIMETRAZINE is dispensed as a multi-dose, 35 mg tablet. This medication is short acting and is usually eliminated from the body within 24 hours. Otherwise, it is essentially the same as Phentermine.

HUMAN CHORIONIC GONADOTROPIN (hCG) is a hormone that is secreted by the placenta during pregnancy. Studies have shown that it may be responsible for fat metabolization or increased fat loss, when used with the proper dietary protocols. While HCG is not approved for weight loss, federal laws do allow for physicians to use approve drugs "off-label". This is a common practice in medicine.

As with any medication, some people may experience side effects. The most common reported side effects in women were breast tenderness and changes in menses. Contraindications include a history of breast cancer, ovarian cancer, endometrial cancer and testicular cancer in men. Anyone with a past history of the conditions listed should not take HCG. **If you experience any problems with the medications or any other aspect of our program, please CALL OUR OFFICE.** We will be glad to assist you in any way that we can.

As a condition of treatment;

1. I understand that HCG is not approved by the FDA for the treatment of Obesity.
2. I agree to follow all of the guidelines set and to take my medications as prescribed by Complete Clinics Clinician Staff.
3. I have been informed of the possible side effects that may accompany my treatment with the medications.
4. I have reviewed the information pages and understand its uses, effects, side effects and contraindications for use. I understand this is an "off label" usage of these medications.
5. I understand that I may get my prescriptions filled at a pharmacy of my choice ($55.00 fee will apply with any patient request for written prescription of appetite suppressants).

I fully understand and agree to all conditions set forth in my treatment and agree to all of the above statements.

Patient Signature: ____ **Date:**________________

(Or Parent or legal guardian if a minor.)

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Complete Clinics, Ltd. – (Oakbrook, Gurnee, Oak Lawn,) (hereinafter collectively referred to as "Complete Clinics, Ltd.) to use and disclose protected health information about me to carry out treatment, payment and healthcare operations.

With this consent, Complete Clinics, Ltd., may call, mail, and e-mail to my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. Any mailed items should be marked personal and confidential.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I have the right to request in writing that Complete Clinics, Ltd., restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting Complete Clinics, Ltd., use and disclosure of my protected health information to carry out treatment, payment, and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Complete Clinics, Ltd., may decline to provide treatment to me.

CONSENT FOR CARE

I agree to treatment and intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name: ____

Patient Signature: ____

Date: ____

COMPLETE IF PATIENT IS A MINOR CHILD. (Under the age of 18)

I,______________________________, being the parent or legal guardian of ________________________, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive care at Complete Clinics, Ltd.

______________________________ ______________________________

Signature Date

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this form, but was unable to do so as documented below:

Date:	Initials:	Reason:

MEDICAL HISTORY QUESTIONAIRE

Name: ______________________ **DOB:** ____________ **DATE:** ______________

A. Allergies to foods or medications: ☐ NONE

____

B. Habits: Smoke? Y N How much? __________
Alcohol? Y N How much? __________

C. Family History

	Mother	Father	Other
Cancer	______	______	______
If yes, what type?	______		
Diabetes	______	______	______
Heart Disease	______	______	______
Hypertension	______	______	______
Psychiatric Disorder	______	______	______
Stroke	______	______	______
Obesity	______	______	______
Osteoporosis	______	______	______

D. List all current medications: ☐ NONE

____

____

E. List all hospitalizations: ☐ NONE

____

____

F. List all surgeries: ☐ NONE

____

____

G. Chronic Illnesses: ☐ NONE

____

____

H. Alcoholism or drug problem? Y N
If yes, describe: ______________________________________

____

Directions: Please circle **Y** (yes) or **N** (no) for each question. Answer all questions. If unsure, circle the truer one.

Respiratory System

Shortness of breath (at rest)	Y	N
Night sweats	Y	N
Productive cough	Y	N
Bloody cough	Y	N
Tuberculosis	Y	N
Pneumonia	Y	N
Emphysema	Y	N
Asthma	Y	N
Sleep apnea	Y	N

Cardiovascular

Chest pain	Y	N
Hypertension	Y	N
Heart attack	Y	N
Heart failure	Y	N
Heart murmur	Y	N
Mitral valve prolapse	Y	N
Palpitations (racing heart beat)	Y	N
Peripheral vascular disease	Y	N
Edema (swelling of hands/feet)	Y	N

Gastrointestinal

Abdominal pain	Y	N
Heartburn	Y	N
Ulcer	Y	N
Acid reflux	Y	N
Vomiting/Nausea	Y	N
Excessive pain	Y	N
Rectal bleeding	Y	N
Colitis	Y	N
Gallstones	Y	N
Constipation	Y	N
Diarrhea	Y	N

Psychological

Depression	Y	N
Bipolar depressive illness	Y	N
Schizophrenia	Y	N
Anxiety/Panic Disorder	Y	N
Panic attacks	Y	N

Neurological

Headaches	Y	N
Dizziness	Y	N
Numbness	Y	N
Epilepsy	Y	N
Seizure disorder	Y	N
Fainting	Y	N

Genitourinary

Enlarged prostate	Y	N
Frequent night time urination	Y	N
Blood in urine	Y	N
Burning upon urination	Y	N

Ears, Eyes, Nose, & Throat

Seasonal allergies	Y	N
Hearing loss	Y	N
Glaucoma	Y	N
Cataracts	Y	N

Endocrine

High thyroid (hyper)	Y	N
Low thyroid (hypo)	Y	N
Diabetes	Y	N
Low blood sugar	Y	N
Gout	Y	N

Bones, Joints, Muscles

Aching muscles/joints	Y	N
Low back pain	Y	N
Muscle cramps	Y	N
Osteoporosis	Y	N
Arthritis	Y	N

Other

Cancer	Y	N
Anemia	Y	N
Fatigue	Y	N
Hot/Cold spells	Y	N
High cholesterol	Y	N

Patient Signature: ______________________________

WOMEN
(Please answer the following)

Date of last menses (period): ___________________
Date of last PAP: ____________________________
Date of last Mammogram: ______________________
Any pregnancies: Y N How many? _________
Are you pregnant now? Y N
Are you breast feeding? Y N
Are you post menopausal? Y N
Abnormal female bleeding? Y N

Birth control methods? (circle one)

Tubal Essure Diaphragm IUD Pills Rhythm

Condoms Depo-Provera Vasectomy

WEIGHT HISTORY

1. I have tried to lose weight __________times in the last 5 years.

2. I have tried:
   ______Jenny Craig ______Weight Watchers
   ______Nutrisystem ______Seattle Sutton
   ______Healthy Weigh ______Inches-A-Weigh
   ______Other_________________________________

3. I lost: ______lbs.
   ______didn't lose any.
   ______gained back what I lost.

4. These medications have helped me lose weight in the past.
   ______Phentermine (Fastin, Ionimin, Adipex)
   ______Diethylpropion (Tenuate)
   ______Phendimetrazine (Melfiat, Bontril)
   ______Pondimin
   ______Redux
   ______Didrex
   ______"Phen-Fen"

5. The medications that I took:
   ______Gave me no side effects.
   ______Made me ill, and I had to stop.

Please answer each question as honestly as you can. If you do have a problem with compulsivity, it will be easier for you to lose weight if you are also treated for this condition. The doctor will discuss this with you during your consultation.

1. Do you binge every week? Y N
2. Are you concerned with your body image? Y N
3. Do you induce vomiting when you overeat? Y N
4. Do you use laxatives or diuretics? Y N
5. Do you have an obsession with food? Y N

If you answered Y (yes) to 3 or more of these questions, it is possible that you may have a compulsive eating problem, or are well on the way to having one.

Additional Comments and Thoughts

____
____
____
____
____
____
____
____
____
____
____
____

I understand that it is my responsibility to notify the physician of any problems I may have with my program or medications. I will notify my physician if my family doctor prescribes any medications or treats any illness which has not been previously reported to this clinic. I acknowledge that I have read and understand the above and will assume full responsibility for relating my medications to this clinic and my family doctor.

_______________________________ _______________________
Patient Signature Date