Patient Intake Form I-Lipo Xcell

Patient Name: (Last)______________________________(First)____________________________(MI)___
Patient Address: ____
City: ____ State: ______________ Zip: ________________
Home Phone: ___________________________________Cellular: __________________________ ______
Email Address:____
Birthdate: ____Age: _________Sex: M F
Occupation:____

In Case of Emergency Contact:
Name: ____________________________________Relationship: _______________ Phone: ______________
Primary Physician: ____ Phone: ______________
Referred by: ____

Weight History:
To the best of your knowledge are you in good health? Yes______No______(If no please explain)_____
____
When did you first become overweight? (your age then) _________ (year) _________
How did your weight gain start? Describe the cause of your weight gain:__________________________
____
Your present weight: _______________ your weight goal: _______________ height: ____________
Describe any previous methods of weight loss and when they were performed: (e.g. diets, pills, injections, Hypnosis, etc)____
Were you successful with any of the above weight loss methods? Yes________No________(If no please explain why)____
Where and when do you do most of your overeating?____
How often do you eat out? (restaurants and fast food)____
What restaurants do you visit the most?____
Do you plan the meals in your home? Yes______ No_____if no who plans the meals?_______________
When you grocery shop do you use a list? Yes______ No_______
If you don't grocery shop who does?____
Location of home food consumption? (dinner table, in front of the tv or computer?)_________________
____
Would you consider yourself a stress and/or emotional eater? Yes_______ No_________
Do you snack a lot in the evenings and/or before bed? Yes________ No________
Do you smoke? No_______ Yes_______ How many packs daily?_____________ How many years have you been a smoker?_________________ Do you have future plans to quit? No______ Yes______
List any allergies to medications:____
Current medications (prescribed and/or OTC):____
____

Medical History: (Please check if you have had any of the following):
☐ Drug Abuse ☐Gallbladder Disorders
☐ Measles ☐ Scarlatina ☐ Influenza ☐ Mumps
☐ Diphtheria ☐ Rheumatic ☐Cancer Type: _______________ ☐ Polio Cont….
☐ Whooping Cough ☐ Frequent Colds ☐ Chickenpox ☐ Tonsillitis
☐ Scarlet Fever ☐ Pneumonia ☐ Diabetes:Type: ___________

Family History :(If you were adopted please leave this area and the area below blank)
Father: Health ______________ Age ______ Deceased _____ at age _____ Cause ____________________
Mother: Health ______________ Age ______ Deceased _____ at age _____ Cause ___________________
# of siblings:_______ # living______ #deceased: ________ Cause ______________________________

Family Diseases: Check diseases known in your blood relatives (not yourself)
☐ High blood pressure ☐ Allergy ☐ Heart trouble ☐ Anemia
☐ Migraine ☐ Bleeding (abnormal) ☐ Dropsy ☐ Epilepsy
☐ Strokes ☐ Cancer ☐ Diabetes ☐ Nervous breakdown
☐ Kidney disease ☐ Syphilis or (bad blood) ☐ Suicide ☐ Obesity
☐ Arthritis ☐ Rheumatic ☐ Fever ☐ Other __________________________

Examinations:
Date of most recent physical examination: Month/Year____
Was your examination for a well visit or sick visit?____
Hospitalizations in the last year: Month:_____________Reason:___________________________________
Were any of the following tests performed in the last year? X-Rays: Chest ________Stomach _________
Gallbladder _____ Kidney ______Colon ________Electrocardiogram (heart tracing) ________
Blood tests: ___________________ Date of last pap (cancer smear): ____________

Do you currently have or recently recovered from any of the following?

☐ High Blood Pressure	☐ Eczema	☐ Hives	☐ Joint pains	☐ Muscle aches
☐ Arthritis	☐ Limitation of motion	☐ Backache	☐ Leg pains	☐ Alcohol Abuse
☐ Pain or stiffness (neck)	☐ Goiter	☐ Swelling, enlarged glands	☐ Asthma	☐ Lung disease
☐ Depression	☐ Emphysema Bronchitis	☐ Heart disease	☐ Eating Disorders	☐ Shortness of breath
☐ Heart Palpitation or fluttering	☐ Chest pain	☐ Lips or nails turn blue	☐ Tire easily	☐ Swelling of ankles
☐ Indigestion	☐ Nausea or vomiting	☐ Abdominal pain	☐ Gas or bloating	☐ Diarrhea
☐ Hard bowel movements No. of bowel movements - daily _____	☐ Colitis	☐ Jaundice	☐ Hemorrhoids (piles)	☐ Bleeding or black stools
☐ Hernia	☐ Drug Abuse	☐ Kidney disease	☐ Bladder disease	☐ Kidney stones
☐ Painful urination	☐ Pus or blood in urine	☐ Albumen or sugar in urine	☐ Dribbling of urine	☐ Varicose veins
☐ Nervousness or anxiety	☐ Trouble sleeping	☐ Frequent Headaches	☐ Diabetes	☐ Gallstones
☐ Fainting	☐ Convulsions	☐ Numbness and/or tingling in hands or arms	☐ Loss of consciousness	☐ Neuritis or Neuralgia
☐ Migraines	☐ Easily tired	☐ Osteoporosis	☐ Liver Disease	

Menstrual History:
Hysterectomy? No_________ Yes_________Month/Year Performed______________________________
Ablation? No___________Yes__________Month/Year Performed______________________________
How many days of bleeding?_______________Do you suffer from painful periods? No___________
Yes________ if yes please explain:____
Amount of flow: Light____________Medium___________Heavy__________
When was your last menstrual period? Date:_____________________________
Bleeding between periods? No______Yes______Bleeding after intercourse? No________ Yes________
Frequent irritation or discharge? No_______ Yes________
Frequent itching or burning? No_______ Yes________
Current birth control method being used:____

Readiness Ruler:
How important is this weight loss change to you right now?
0 1 2 3 4 5 6 7 8 9 10
Not Somewhat Very
How confident are you about making this weight loss change?
0 1 2 3 4 5 6 7 8 9 10
Not Somewhat Very

Please list any comments or information that you think may be useful:
____
____
____
____

Financial Policy:
Thank you for selecting Pure Lifestyle Center/Ageless Beauty Medical Spa for your health care needs. We are honored to be of service to you and your family. 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 agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

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

____ _______________________________________

Patient's Signature Date