

New Client Intake Form

Personal Information

Last Name		First Name		M.I.
Date of Birth / /		E-mail		
Mailing Address				
City			State	Zip Code
Home Phone ()		May we leave a message at this number?		<input type="radio"/> Yes <input type="radio"/> No
Alternate Phone ()		May we leave a message at this number?		<input type="radio"/> Yes <input type="radio"/> No
Occupation			Hours per Week	

Medical Provider Information

Primary Healthcare Provider		Last Visit
Location of Your Provider		

Health Information

Primary Health Concerns	
Past Hospitalizations	
Past Surgeries	
Current Medications	
Current Supplements	
Allergies (food/drug/environmental)	
Current Exercise (type and frequency)	
Do you smoke? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Previously	Do you drink caffeine? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Previously
How often do you drink alcohol?	

Do you have, or have you ever had, any of the following (check all that apply):

<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Low Blood Sugar
<input type="checkbox"/> Anorexia or Bulimia	<input type="checkbox"/> Eye Problems	<input type="checkbox"/> Neurological Disorders
<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Panic Attacks
<input type="checkbox"/> Any Psychiatric Disorder	<input type="checkbox"/> Heart Attack or Angina	<input type="checkbox"/> PMS or Hot Flashes
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Murmurs	<input type="checkbox"/> Seizures or Epilepsy
<input type="checkbox"/> Blood Disorders	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Swollen Ankles
<input type="checkbox"/> Chronic Constipation	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Chronic Fatigue Syndrome	<input type="checkbox"/> High Cholesterol Triglycerides	
<input type="checkbox"/> Chronic Lung Problems	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Other Serious Health Conditions

If you checked off any of the conditions on the previous page, please provide further details:

Female Client Only

Start date of your last menstrual cycle / /	Are you breastfeeding? <input type="radio"/> Yes <input type="radio"/> No
Are you pregnant or trying to get pregnant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Trying <input type="radio"/> Using birth control	

Family History

Cancer <input type="radio"/> Yes <input type="radio"/> No	If yes, who?
Diabetes <input type="radio"/> Yes <input type="radio"/> No	If yes, who?
Obesity <input type="radio"/> Yes <input type="radio"/> No	If yes, who?
Heart Disease or Stroke <input type="radio"/> Yes <input type="radio"/> No	If yes, who?

Nutrition & Diet

Do you follow a particular diet? <input type="radio"/> Yes <input type="radio"/> No	If yes, please describe:
Have you gained or lost weight recently? <input type="radio"/> Yes <input type="radio"/> No	If yes, please describe:
What are the names of the weight loss programs or diets that you have tried?	
Do you drink diet soda or use artificial sweeteners?	<input type="radio"/> Yes <input type="radio"/> No
Do you normally eat breakfast?	<input type="radio"/> Yes <input type="radio"/> No
How much weight would you like to lose?	

Please list foods that you eat regularly for:

Breakfast
Lunch
Dinner
Snacks
Normal water intake

Signature

My signature below warrants that I have completed this questionnaire truthfully and accurately. My records will be kept confidential and will only be shared with the physicians and staff. My written consent is required for any sharing of information outside of MediPro Direct Slim™.

I understand that the staff and physicians are providing services to me related specifically for, and only to, the issue of medically supervised weight loss. The interview with the physician is related only to the area of medically supervised weight loss. The doctor’s examination does not represent a complete history and physical or any other area of medical practice.

Print Name	
Signature X	Date / /
Legal guardian's signature for minors X	Date / /

How did you hear about the MediPro Direct Slim™ Program?

Name of Referral	Relationship
Internet (please be specific)	
Other (please be specific)	

Do you know anyone who has lost weight on the MediPro Direct Slim™ Program? Yes No

Have you read *The Weight Loss Cure* by Kevin Trudeau? Yes No

Have you read *Pounds and Inches: The New Approach to Obesity* by Dr. Simeons? Yes No

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practice. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

MediPro Direct Slim™ reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Additional Disclosure Authority

In addition to the allowable disclosure described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

Personal Representative (optional)	Relationship
Print Client Name	
Client or Personal Representative Signature X	Date / /

Signature

I have carefully read and initialed the preceding sections of this consent for treatment. My questions have been answered satisfactorily by the doctor and doctor's associates. I realize that the doctor nor any personnel of MediPro Direct Slim has made no absolute guarantees to me regarding cure or improvement of my condition. I understand that I am free to discontinue participation in this treatment program at any time. I agree to the use of arbitration to settle legal controversies that may arise as part of my treatment program.

Print Name	
Signature X	Date / /
Legal guardian's signature for minors X	Date / /

Statement of Privacy Practices

Office Policy

Our office is dedicated to protect the privacy rights of our clients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal HealthCare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Probability and Accountability Act and the state of Washington. This personal health information will never be otherwise given to anyone, even family members, without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future clients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality healthcare, implement payment activities, conduct normal healthcare practice operations, and comply with the law. This may include your name, address, telephone number(s), social security #, employment data, medical history, health records, etc.. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental official under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail/answering machine messages, postcards, newsletters and special events.

Client Rights

You have the right to request copies of your healthcare information; to request copies in various formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for use other than stated above. All such requests must be in writing. We may charge you for copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a client at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

Cancellation Policy

Signature

I understand that I will pay for my sessions at the time service is rendered I agree to cancel/or reschedule my sessions at least 24 hours in advance. If I don't give 24 hours notice, I understand that I will be responsible for the entire appointment cost.

I have read this disclosure in detail and I understand the terms and refund/cancellation policy.

Print Name	
Signature X	Date / /

Please send me e-mail specials and news

Name
E-mail

We will never share your email address with another subscription provider or third party vendor.