ENDURANCE WELLNESS + WEIGHT LOSS
New Patient Intake Form

Date: ____/_____/_____ **Please Print Legibly**

Patient Name: (Last)________________________________(First)______________________________(MI)_________
Patient Address: ____
City: ____ State: _______________ Zip: _______________________
Home Phone: ____________________________________Cellular: __________________________________
Birthdate: ____Age: _________Sex: M F

Employment Information:
Patient Employer: ____ Occupation: ______________________________
City: ____ State: _______________ Zip_________________
Work phone No: ____Ext. ________________________________

In Case of Emergency:
Name: _____________________________________Relationship: _______________ Phone:_____________________
Primary Care Physician: ____ Phone:_____________________
Referred by:

☐ Patient Referral ☐ My physician (please identify) ☐ Internet
☐ Printed Ad (please identify) ☐ Passing by our office ☐ Other (please describe)

EMAIL ADDRESS: ____

We are primarily paperless. Please indicate if it is acceptable for us to use the above email for information &/Or special offers? YES_____ NO_____

Past History: (Please check if you have had any of the following):

☐ High Blood Pressure ☐ Stroke ☐Arthritis ☐ Sleep Apnea
☐ Diabetes ☐ GERD (Reflux) ☐ Kidney Disease ☐ Anemia
☐ High Cholesterol ☐ Depression/Anxiety ☐ Hepatitis ☐ Abnormal Bleeding
☐ Heart Disease ____________ ☐ Mental Illness ☐ Migraines ☐ Seizure Disorder
☐ Lung Disease _____________ ☐ Thyroid Disease___________ ☐ Allergies (type)_________________________
☐ Cancer, Type:___________________________________ ☐ Other Diseases __________________________________

☐ **SURGERIES:(& dates)** ____
____

Current Medications (including vitamins, birth control pills): _______________________________________

Allergies to medicines, foods, etc____

Family History:
Father: Health ______________ Age ______ Deceased _____ at age _____ Cause ____________________________
Mother: Health ______________ Age _______ Deceased _____ at age _____ Cause ___________________________
# of siblings:_______ # living______ #deceased: ________ Cause _______________________________________
Family Diseases: list diseases known in your blood relatives (not yourself)
____
____☐

Examinations:
Date of last physical examination ______________ Reason:____
Hospitalizations _________ Dates ____________ Reason:____
Other ____________________________________Date of last laboratory tests:______________________________

Review of Systems (check all that apply) **?**

☐ Difficulty Seeing	☐ Heart Burn	☐Headache /Migraines	☐ Chest Pain	☐ Trouble Sleeping
☐ Double Vision	☐ Nausea or Vomiting	☐Seizure	☐ Palpitations	☐ Nervousness
☐ Trouble Hearing	☐ Stomach Pain	☐ Muscle Aches	☐Dyspnea with exertion	☐ Depressed mood
☐ Allergies	☐ Diarrhea	☐ Joint Pains	☐	☐ Lack of Energy
☐ Trouble Swallowing	☐ Constipation	☐Weakness of extremity	☐ Fainting spells	☐ Night Sweats
☐ Trouble breathing	☐ Blood in bowels	☐ Swelling of ankles	☐ Itching	☐ Nails turn blue
☐ Cough	☐ Kidney stones	☐ Numbness	☐ Rash	☐
☐ Wheezing	☐ Painful Urination	☐ Calf pain with walking	☐ Easy bruising or bleeding	

Weight History:
When did you first become overweight? (your age then or year)_____________________________________
How did your weight gain start? Describe any circumstances: _______________________________________
____
What do you think is the cause of your weight problem:____
____
Your present weight: ______________ your weight goal: _________________________height: ____________
What was your highest weight? (excluding pregnancy) _______your age then _________# of years ago:________
What was your lowest weight? ______________your age then _______________# of years ago:______________
Have you ever stayed the same weight for 10 years or more? Yes/ No
Have you attempted to lose weight before? ______ most lbs lost:_____________how long it took:____________
Describe previous methods of weight loss (e.g. diets, pills, injections, hypnosis, acupuncture) and describe your results:____
____

Where and when do you do most of your overeating?____
____

How many meals do you eat a day? ______ How many times do you snack a day? ________How many times a week do you eat out? ______What foods do you eat when snacking?
____

HOW MOTIVATED ARE YOU TO LOSE WEIGHT NOW? (1- NONE, 10 – VERY MOTIVATED)
____

Do you currently have any medical concerns? Please List:_______________________________________
____
____

All Statements on this patient intake form are accurate and true to the best of my knowledge. I understand that treatments will be based on the information provided herein. If I willingly withhold knowledge from my treating physician, I accept full liability from any consequences arising there from.

______________________________________ ______________________________________
Patient's Signature Date

Financial and Refund Policy:
Thank you for selecting Endurance Wellness and Weight Loss 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.

Due to our financial obligations immediately following any of your purchases, our policy is that all sales are final. No refunds are allowed, and no exchanges are allowed.

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

____ ______________________________________

Patient's Signature Date

LAB CONSENT

PLEASE INITIAL ONE OF THE FOLLOWING:

________I have received lab within one year and will bring a copy before my next visit to have filed in my records at Endurance Wellness and Weight Loss.

________I have not had lab drawn within one year but will schedule an appointment with my primary care physician to have these lab tests performed. I will bring a copy of this lab as soon as possible to be filed in my records.

________ I am interested in obtaining labs ordered via Endurance Wellness and Weight Loss and will be responsible for any unpaid labs that are completed with my approval.

________I am 35 years old or younger and I have no history of any medical illnesses. I do not have medical insurance so I decline to have lab tests taken at this time. I understand the risks and accept responsibility for any medical problems, including fatal illnesses, that may arise from taking Adipex, HCG, or any other weight loss supplements.

____

Patient's Signature

I have been provided and have read the EWW Privacy Policy: YES NO _________(initials)

I have read the Release of Liability statement and agree to provide my release: YES NO _________(initials)

I have read the Confidentiality Agreement and agree with its terms: YES NO ________(initials)