Principled Healthcare Solutions, Inc.

PATIENT INFORMATION SHEET

First Name: _____ Last Name: _____ MI: _____

Preferred Name: _____ E-mail Address: _____

Social Security #: _____ Birth Date: _____ Age: _____

Gender: _____ Marital Status: _____ Height _____ Weight: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Occupation: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Primary Physician: _____

REFERRAL SOURCE: _____

Accident Information

Is this visit due to an accident? □ Yes □No If yes, what type? □Auto □Work □Other_____
Has it been reported? □ Yes □No If yes, to whom? _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGN (X) _____ **DATE** _____

Patient Health Evaluation – Weight Loss

Today's Date: _____

Name: _____ **Birth date:** _____ **Age:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **E-mail Address:** _____

Gender: □ Male □ Female **Height:** _____ **Weight:** _____

Doctor's Name: **Address:** **Phone:**

_____

_____

_____

Allergies: Please check all that apply.

__ Penicillin	__ Morphine	__ Dye Allergies	__ Pet Allergies
__ Codeine	__ Aspirin	__ Nitrate Allergy	__ Seasonal (Pollen)
__ Sulfa Drug	__ Food Allergies	__ Unknown Allergies	__Other: _____

Please describe the allergic reaction you experienced and when it occurred.

_____

_____

Medical Conditions/Diseases: Please check all that apply.

_____ Diabetes	_____ Osteoporosis	_____ High blood pressure	_____ High Cholesterol
_____ Heart Disease	_____ Cancer	_____ Kidney Disease	_____ Liver Disease
_____ Thyroid Disease	_____ Anemia	_____ Smoker	_____ Fibromyalgia
_____ Nausea	_____ Vomiting	_____ Acid Reflux	_____Diarrhea
_____ Constipation	_____ Ulcers	_____ IBS	_____ Diverticulitus
_____ Crohns/IBD	_____ PCOS	_____ Chronic Fatigue	

_____ Pregnant _____ Number of months _____ Breastfeeding

Other (please list): _____

_____

Family medical history (please list): _____

_____

Diet and Lifestyle History: Please check all that apply.

How many meals do you usually eat each day?___

Do you skip meals? _yes / no_ ___times daily / weekly Do you eat out? _yes / no_ ____times daily / weekly

Typical Breakfast _____ Lunch_____

Dinner _____ Snacks _____

Food cravings: salty / sweets / fats / carbs other _____

_____ Kosher _____ Vegan _____ Vegetarian (ovo/lacto) _____ Lactose intolerant

Please indicate if you are able to tolerate small amounts of the following: __ milk __cheese __yogurt

Exercise: ____times daily / weekly types of exercise _____

Describe your daily activity level (outside of exercise) _____

What is your occupation? _____

Would you describe your job activity as

Sedentary Light Activity Moderate Activity Heavy Activity

How long is your commute to work?_____

Do you eat meals in your car (e.g. to and/or from work?) Y N Sometimes

Family:

Marital Status: Married Separated Divorced Single Widowed

Number and ages of Children:_____

Current Prescription Medications: Please check all that apply within the last month.

_____ Antacids	_____ Antibiotics	_____ Anticonvulsants	_____ Antidepressants
_____ Antifungals	_____ Aspirin/Ibuprofen	_____ Asthma inhalers	_____ Beta blockers
_____ Chemotherapy	_____ Cortisone	_____ Diabetic medications	_____ Estrogen/Progesterone
_____ Diuretics	_____ Heart medications	_____ High blood pressure	_____ Hormone Therapy
_____ Laxatives	_____ Insulin	_____ Oral contraceptives	_____ Radiation exposure
_____ Sleeping pills	_____ Thyroid medication	_____ Tylenol/acetaminophen	_____ Ulcer medications

Medication Name Strength Date Started Times Per Day

_____

_____

_____

_____

_____

_____

Other medications and dosages (if known): _____

Over –the-counter medications: Please check all products that you use regularly or occasionally.

Pain Relievers:

___ Aspirin

___ Acetaminophen

Anti-inflammatory:

___ Ibuprofen

___ Naproxen

Combination Cold Products:

___ Cough Suppressant

___ Antihistamine Product

___ Decongestant Product

Other:

___ Sleep Aids

___ Antidiarrheals

___ Laxatives/Stool Softeners

___ Diet Aids/Weight Loss Products

___ Antacids

___ Acid Blockers

___ Others

_____

_____

Supplements: Please identify and list the products you are using.

- ☐ Vitamins (examples: multiple or single vitamins such as B complex, E, C, beta carotene)
- ☐ Minerals (examples: calcium, magnesium, chromium, etc.)
- ☐ Herbs (examples: Ginseng, Ginkgo Biloba, Echinacea, herbal /medicinal teas, tinctures, remedies, etc.)
- ☐ Enzymes (examples: digestive formulas, papaya, bromelain)
- ☐ Nutrition/Protein Supplements (examples: Protein powders, amino acids, fish oils, etc.)
- ☐ Others: _____

Supplement	Amounts	Reason

List Use of:			Qty	Daily	Weekly	Monthly	Occasionally
Tobacco	☐ No	☐ Yes	_____	☐	☐	☐	☐
Alcohol	☐ No	☐ Yes	_____	☐	☐	☐	☐
Caffeine	☐ No	☐ Yes	_____	☐	☐	☐	☐

Weight History:

Which of the following family members have/had weight control problems?

☐ Mother ☐Father ☐Brother/Sister ☐Paternal Grandparents
☐ Maternal Grandparents ☐Children

Were you an overweight child? ☐Yes ☐No

How long do you feel that your weight has been a problem? _____

List your approximate weight at the following times?

- High School Graduation _____
- Marriage _____
- Birth of your first child (men and women) _____
- 5 years ago _____
- 1 year ago _____
- Maximum weight as an adult _____
- Minimum weight as an adult _____

List any medical problems, injuries, or life events that have significantly affected your weight. Include year and weight change.

_____

_____

List any diets attempted: _____

List any medications or diet aids that you have tried for the purpose of losing weight:

_____

_____

_____

In your opinion, what contributes to your excess weight?

☐Portion size ☐Compulsive eating ☐Lack of Exercise ☐Eating too much fat/sugar
☐Nervous eating ☐Emotional eating ☐Depression ☐Stress
☐Always hungry ☐Boredom

With whom do you typically eat? ◯ Alone ◯ Family ◯ Other (explain) _____

Who typically does the food shopping for your household? _____

Who usually prepares the food you eat at home? _____

Please list any food allergies or intolerances. _____
_____

Have you ever been a binge eater? ◯ Yes ◯ No
Have you ever had a bulimia or anorexia disorder? ◯ Yes ◯ No
Are you more of a structured eater or a haphazard eater? Circle one. Explain _____
_____

What eating habits do you have that bother you or contribute to your weight problem?
_____

Briefly describe a "typical" day's food intake:
Breakfast _____
Lunch _____
Dinner _____
Snacks _____

Patient Questionnaire:

Are you happy with your current weight? ◯ Yes ◯ No

How much weight do you want to lose? _____

By which date do you want to lose this weight? _____

Why do you want to lose weight? _____

Please check the symptoms you experience:

	Absent	Mild	Moderate	Severe
Stress				
Weight gain				
Weight loss				
Insomnia				
Lack of energy				
Night blindness				
Depression				
Diarrhea				
Dry skin				
Decreased appetite				
Fatigue				
Nosebleeds				

Gingivitis				
Muscle pain				
Chronic pain				
Fluid Retention				
Constipation				
Tingling fingers/toes				
Numbness				
Loss of Memory				
Trouble breathing				
Recurrent infections				
Light sensitivity				
Decreased Sex Drive				
Nervousness				
Brittle nails				
Hair loss				
Headache				
Nausea				
Skin rashes				
Irritable				
Altered taste/smell				
Increased grey hair				
Confusion				
Dizziness/lightheadedness				
Poor concentration				
Decreased alertness				
Stiff muscles				
Mood				
Cold hands and feet				
Shortness of breath				
Increased bleeding				
Cramps				
Easy bruising				

Principled Healthcare Solutions, Inc.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient you have the following rights:

1. The right to inspect and copy your information:
2. The right to request corrections to your information:
3. The right to request that your information be restricted:
4. The right to request confidential communications:
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, the name and phone number of our contact person is listed on this page.

Effective Date of this Notice	
Contact Person	Cindy Grimes
Phone Number	513-887-9400

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I understand that if I have questions or complaints regarding my privacy rights, that I may contact the person listed above. I further understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, modified or changed in any way.

_____

Patient or Representative Name (please print)

_____ _____

Patient or Representative Signature Date

☐ Patient refused to sign ☐ Patient was unable to sign because _____