MD WELLNESS CENTER AND MED SPA

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NEW PATIENT INTAKE FORM

Don't forget to save this document once completed! Information is not automatically transmitted when input.
To return, either print and bring a copy to your appointment or email as an attachment to contact@myTrimMD.com

Date: _____

Please Print:

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Email: _____

Date of Birth: _____ SSN#: _____ Sex: Male / Female

Please consent to receive automated text and voice mails at above phone number: _____ *(Initial)*

Marital status: Single ☐ Married: ☐ Widowed: ☐ Divorced: ☐

How Did You Hear About us? Social Media ☐ Google ☐ Billboard/Drive By ☐

Referral ☐ TV/Commercial ☐

Physician Info:

Referring Physician: _____ Phone: _____

Family MD: _____ Phone: _____

Emergency Contact:

Name: _____ Phone: _____

Relationship: _____

What are your main health concerns that you would like to be addressed?

☐ Weight ☐ Poor sleep ☐ Low libido

☐ Lack of energy ☐ Lack of focus

Personal Weight History

Goal Weight: _____

From what age did you begin having weight problems? _____

Weight one year ago: _____

Are you in good health at the present to the best of your knowledge? Yes ☐ No ☐

If No, Please provide details: _____

What has been your maximum lifetime weight (non-pregnant), and when? _____

How much weight do you expect to lose? _____

What weight loss programs or diets have you tried? _____

Which method of weight loss do you consider most successful for yourself? _____

Medical History:

☐ Abnormal Periods ☐ Asthma ☐ Diabetes: Type 1 Type 2

☐ Eating Disorders- Binge eating ☐ Glaucoma ☐ Heart Disease

☐ High Blood Pressure ☐ High Cholesterol ☐ Sleep Apnea

☐ Insomnia ☐ Kidney Disease ☐ Polycystic Ovarian Syndrome

☐ Thyroid Disease ☐ Alcohol Abuse ☐ COPD

☐ Gall Stones ☐ Kidney Stones ☐ Back Pain

☐ Previous head bleed ☐ Stroke ☐ Seizure Disorders

☐ Depression/Mental Health ☐ Migraines ☐ Menopausal symptoms

☐ Blood clots ☐ Heart failure ☐ Cancer

☐ Constipation ☐ Anxiety ☐ HIV

☐ Abdominal Aortic aneurysm ☐ Carotid artery disease/ surgery ☐ Peripheral vascular disease

☐ Gastric bypass/ Sleeve ☐ LAP band

Are you undergoing any significant lifestyle changes?

Any other Hospitalizations, surgeries, or significant illness (Please specify the date and why and where?):

Gynecologic History:

	Yes	No
Are you pregnant now?	☐	☐
Are you planning to get pregnant?	☐	☐
Are you breastfeeding now?	☐	☐
Are you update with Mammogram/PAP?	☐	☐

Sexual Wellness:

How is your libido and sexual health?

If you have any concerns, would you like to discuss this further?

Current Medications, including Over the Counter Medications:

Medications	Medications

Past Medications Used:

Drug / Food / Environmental Allergies:

Your Preferred Pharmacy:

Pharmacy Name:

Pharmacy Address:

Pharmacy Zip Code:

Pharmacy Phone Number:

Have you ever had an episode of Acute Angle Closure Glaucoma?

☐ Yes ☐ No

Family Medical History:

☐ Disease	☐ Cancer	☐ Diabetes	☐ Heart Disease
☐ High Cholesterol	☐ Obesity	☐ Stroke	☐ Sudden Death < 40 years old

Family History of weight: Are your family members Overweight?

☐ Yes ☐ No

Social History:

Smoke/ Tobacco Use:	☐ Yes	☐ No	
Alcohol Use:	☐ Yes	☐ No	
Drug Use:	☐ Yes	☐ No	
Living Situation:	☐ Married	☐ Partner	☐ Alone
Employed	☐ Yes	☐ No	
Hours of Work	☐ Day Time	☐ Night Time	☐ Shift Work

How much TV / Cellphone time you spend on an average day?

Eating Habits:

Of the following, check all that you feel help explain or describe your eating habits:

☐ Thinking about food too much	☐ Eating high-fat foods
☐ Eating in reaction to tension/depression	☐ Uncontrollable binges
☐ Using food as a reward	☐ Overeating at social events
☐ Eating in reaction to boredom	☐ Overeating when alone
☐ Not paying attention to what I'm eating	☐ Continuing to eat even though you are full
☐ Eating too many sweet foods	☐ Eating too quickly

Sleep:

What time do you go to bed? _____ How many hours do you sleep on average? _____

Do you wake up at night frequently? _____ Do you feel refreshed after waking up? _____

How is your energy level during the day?

Lifestyle Habits:

Any Regular Cravings? _____

At what time of day do you begin to crave food? _____

How often do you cook at home in a week? _____

How often do you eat out? _____ Drink POP/fruit juice or sweat tea? _____

Do you eat cheese on regular basis? _____

Do you work out? _____

Do you travel for work? If so, how often? _____

Do you meal prep? _____

How much water do you drink per day? _____ oz/day OR _____ bottles/day

Please Select All That Apply *(Please Specify any selections of 'Other')*

	Time of Day	**Place**	**With Who?**	**What?** (give examples)
BREAKFAST	◯ Before 6am ◯ 6am – 9am ◯ After 9am ◯ I don't eat ◯ Other*	◯ Home ◯ Office ◯ In The Car ◯ Other*	◯ Family ◯ Friends ◯ Coworkers ◯ Other*	◯ Eggs ◯ Toast ◯ Sausage/Bacon ◯ Cereal ◯ Other * Specify
LUNCH	◯ Before Noon ◯ Around Noon ◯ After Noon ◯ I don't eat	◯ Home ◯ Office ◯ In The Car ◯ Other*	◯ Family ◯ Friends ◯ Coworkers ◯ Other* Specify	What are common foods you eat for lunch?
DINNER	◯ Before 6pm ◯ 6pm-9pm ◯ After 9pm ◯ I don't eat	◯ Home ◯ Office ◯ In The Car ◯ Other*	◯ Family ◯ Friends ◯ Coworkers ◯ Other *Specify	For Dinner?
SNACK	What Time(s)? ◯ I don't Snack	◯ Home ◯ Office ◯ In The Car ◯ Other*	◯ Family ◯ Friends ◯ Coworkers ◯ Other* Specify	What Snacks?

Are You Interested In Any Other Services We Provide?

- ☐ Cosmetic Injections
- ☐ Fat Reduction
- ☐ Bra Roll Treatment
- ☐ Brow Lift
- ☐ Cellulite Treatment
- ☐ Botox
- ☐ Double Chin
- ☐ Excess Sweating
- ☐ Lip Augmentation
- ☐ Skin Tightening (Face/Arms)
- ☐ Non Surgical Neck Lift
- ☐ Non Surgical Face Lift
- ☐ Hormone Therapy
- ☐ Hair Regeneration- LASER
- ☐ Hair Regeneration- PRP
- ☐ Micro-Needling for Face
- ☐ Facials
- ☐ IV Nutrition
- ☐ Non Surgical Nose Job
- ☐ Facial Filler
- ☐ Jawline Definition
- ☐ Vitamin Injections
- ☐ Sexual Wellness

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for use or disclosure of protected health information.
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. parts 160 and 164)

1. Authorization
   I authorize ***MIDWEST WELLNESS CENTER AND MED SPA*** (healthcare provider) to use and disclose the protected health information according to HIPPA guidelines.
2. Extent of Authorization
   a. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment for alcohol or drug abuse).
   b. I authorize the release of my complete health record except for the following:
      - Mental Health Records
      - Communicable Diseases (including HIV and AIDS) - Alcohol/Drug abuse treatment - Other (please specify):

      _____
3. This information may be used by the person I authorize to receive this information for medical treatment or consultation, billing, or claims payment or other purposes as I may direct.
4. I understand the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage, and the insurer has a legal right to contest a claim.
5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
6. I understand that when requesting a family member or friend be in the exam room with me when my health is being discussed, the physician is not violating my HIPAA rights. **Initial**_____

_____
Signature of patient or personal representative

_____
printed name of above signed

CONDITIONS OF SERVICE

- I authorize the release of any and all medical records, including but not limited to Radiology, Laboratory, and other ancillary services' results, as well as Histories, Physicals, Correspondence, and Medication information contained or held by any referring primary, pharmacy, or emergency facility.
- I allow fax or electronic transmission of applicable records if necessary.
- I understand payment is due at the time of service
- I agree to pay all reasonable attorney fees/collection costs in the event of default of payment charges.
- I am responsible for any unpaid balances/deductibles on any Medical Weight Loss and Wellness Center accounts.
- I am giving Medical Wellness Center and MedSpa permission to treat my medical condition.
- I certify that the information provided on these documents is true and correct to the best of my knowledge.
- I have read and fully understand the above Consent for Treatment, Financial Responsibility, and Release of Information Authorization.
- We will be checking the urine drug screen on patients based on need.
- _____ I **do** give Medical Wellness Center and MedSpa permission to leave a message at any of the phone numbers I have listed.
- **Refill Policy**: We can refill any Medications over the phone ***except*** for *Controlled Substances*.

_____ _____

Patient's Signature Date

Statement of Patient Financial Responsibility

Patient Name: _____

DOB: _____

The service you have elected to participate in implies a financial responsibility; the responsibility obligates you to ensure payment in full and is required at the time services are rendered. We accept payments in cash, check, credit cards, HSA cards, and FSA cards.

I have read the above policy regarding my financial responsibility to Medical Wellness Center and MedSpa for providing services to the above-named patient or me. I certify that the information is, to the best of my knowledge, true and accurate.

Patient Signature: _____ Date: _____

Guarantor Signature: _____ Date: _____

Weight Loss Program Consent Form

I _____ authorize Medical Wellness Center and MedSpa, Dr. Kesa and whomever they designate as their assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low-calorie diet or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices and academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet, and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that the program's success will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also realize that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

I also understand that while Dr. Kesa addresses other comorbidities while treating for obesity, he is not my primary care doctor responsible for screening, vaccination, or other routine checkups. For that, you need to follow up with your primary care physician. _____

For medication refills, you need to be seen and have proper blood tests done at regular intervals. For controlled substances, you need to be seen every 30 days. For other refills, you need to be seen every 90 days _____

Date: _____ **Time:**

Witness: _____ **Patient:**

Ownership Disclosure: Srinivasu Kesa, is sole owner of Medical Wellness Center and MedSpa

VITAMIN INJECTIONS INFORMED CONSENT

(B12, Lipo B, Lipo C, Vitamin D)

BENEFITS: Cyanocobalamin is a form of vitamin B12 used to treat this vitamin deficiency. Vitamin B12 helps your body use fat and carbohydrates for energy and make new protein. It is also essential for normal blood, cells, and nerves. Our compounded preparation has B12 and Methionine, Inositol and choline, which are excellent options to help with weight loss, body fat loss, and energy.
Vitamin D is a necessary vitamin for the growth and development of bones. It is a fat-soluble vitamin that helps your body absorb calcium and phosphorus. Having the right amount of vitamin D, calcium, and phosphorus are essential for building and keeping strong bones. Vitamin D does just more than keep bones healthy and strong, it also reduces depression and anxiety, increases muscle mass and energy levels, helps with sugar regulation, alter appetite and metabolism.

SIDE EFFECTS: Pain/redness at the injection site, mild diarrhea, itching, or a feeling of swelling all over the body may occur. This medication may cause low potassium levels in the blood (hypokalemia). Tell your doctor right away if any of these unlikely but severe side effects occur - muscle cramps, weakness, irregular heartbeat. Seek immediate medical attention if any of these rare but severe symptoms occur chest pain (especially with shortness of breath), weakness on one side of the body, sudden vision changes, trouble speaking.
Get medical help right away if you have any severe side effects, including symptoms of heart failure (such as shortness of breath, swelling ankles/feet, unusual tiredness, unusual/sudden weight gain).. However, seek immediate medical attention if you notice any symptoms of a serious allergic reaction, including: rash, itching/swelling (especially of the face/tongue/throat), severe dizziness, trouble breathing. This is not a complete list of possible side effects. If you notice other effects not listed above, contact your doctor.

PRECAUTIONS: Before using cyanocobalamin, tell your doctor or pharmacist if you are allergic to it, or cobalt, or if you have any other allergies. Before using this medication, tell your doctor or pharmacist your medical history, especially of: low potassium blood levels (hypokalemia), gout, kidney disease, a specific blood disorder (polycythemia vera), a specific eye disease (Leber's disease), another vitamin/mineral deficiency (especially folic acid and iron). During pregnancy, this medication should be used only when needed. Consult your doctor before breast-feeding.

DRUG INTERACTIONS: Drug interactions may change how your medications work or increase your risk for serious side effects. This document does not contain all possible drug interactions. Keep a list of all the products you use (including prescription/nonprescription drugs and herbal products) and share it with your doctor and pharmacist. Do not start, stop, or change the dosage of any medicines without your doctor's approval. Some products that may interact with this drug are: drugs that may affect blood cell production (e.g., chloramphenicol, anti-cancer drugs, HIV drugs), other vitamins/nutritional supplements (especially folic acid). Certain other drugs may interfere with

laboratory tests for vitamin B12 levels, possibly causing false test results. Tell laboratory personnel and all your doctors if you take any of the following: anti-infective drugs (e.g., amoxicillin, erythromycin), methotrexate, pyrimethamine. Overdose with this medication is very unlikely. However, if someone has overdosed and has serious symptoms such as passing out or trouble breathing, call 911.

Please alert our staff if you have any of the following conditions:

- **Allergy to Cobalt**
- **Gout**
- **Polycythemia Vera**
- **Iron Deficiency**
- **Folic Acid Deficiency**

Frequency of treatment can vary between once weekly to once every 60 days. Your treatment plan will be determined by the provider. **Do not take oral supplements while receiving injections**. You will need regular blood work to check progress and monitor levels while on this medication.

By signing below, I acknowledge that I have read the foregoing informed consent and agree to the treatment with its associated risks. I hereby give consent to perform this and all subsequent Vitamin Injections with the above understood. I hereby release the doctor, the person injecting the Vitamin Injection, and the facility from liability associated with this procedure.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

NAME (Please Print) _____

SIGNATURE _____

DATE _____

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