ABSolute Weight Loss and Nutrition Center L.L.C.
Patient Information and Consent for Treatment

Patient Name ______________________________ Birth Date __________ Age ______ Ht. _____

Married ___ Single ___ Widowed ___ Divorced ___ Separated ___ Home Phone ______________________

Address ____

City ______________________________ State ______________ Zip Code ______________________

Email address ____

I give my permission to confirm appointments by:

Message on answering machine	Yes	No
Message with family member	Yes	No
Message with anyone answering	Yes	No

The phone number you can be reached at to confirm your appointments: ________________________

Employer ____________________________________ Occupation ____________________________________

Work Phone ________________________________ Cell Phone ______________________________________

Family Physician _______________________________ Phone number ________________________________

In case of emergency please notify ____

Phone number _____________________________

How did you hear about us? ____

Were you referred by someone? Name ____

CONSENT FOR TREATMENT

I authorize and direct the Practitioner on staff and his or her associates to perform procedures that in his or her judgment are considered advisable for my treatment. Such treatment might include the use of controlled substances for weight management. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained. The nature, purpose and risks of the procedures and possibilities of complications have been explained to me and I understand that unforeseen conditions might make it necessary to change the form of treatment I will be provided. I also understand that medications can have serious side effects that cannot be controlled by the practitioner or ABSolute Weight Loss and Nutrition Center. I am willing to accept those risks because I want to pursue a weight management plan that I believe will be beneficial to me.

Date ____________ Patient Signature ____

If Patient is a minor, signature of responsible parent ____

Do you suffer from any of the following?

Eye disease or injury…… Yes No
Double vision ………… Yes No
Headaches …………… Yes No
Glaucoma …………… Yes No
Dizziness ……………… Yes No
Kidney trouble ………… Yes No
Jaundice …………… Yes No
Spitting up blood …… Yes No
Asthma or wheezing … Yes No
Difficulty breathing … Yes No
Any trouble with lungs.. Yes No
Gallbladder disease ……. Yes No
Thyroid disease ……. Yes No
Hormone therapy ……… Yes No
Have you become colder. Yes No
Do you have dryer skin.. Yes No
Do you have dryer hair… Yes No
Have you experienced
Recent hair loss ……… Yes No
Difficulty swallowing
food ………………… Yes No
Muscle weakness or
fatigue ………………… Yes No
Stiffness in neck …………Yes No

Loss of urine ……………. Yes No
Frequent urination ……. Yes No
Night time urination… Yes No
Burning/painful urination Yes No
Blood in your urine ……. Yes No
Heart trouble…………….. Yes No
Kidney stones ………….. Yes No
Kidney Disease ………… Yes No
Swelling of hands feet or ankles . Yes No
Peptic ulcer …………….. Yes No
Vomiting blood/food ….. Yes No
Night smothering………. Yes No
Liver trouble ……………. Yes No
Hepatitis ………………… Yes No
Painful bowel movements Yes No
Bleeding with bowel
movements …………….. Yes No
Black stools ……………. Yes No
Hemorrhoids/piles ……… Yes No
Recent change in bowels .. Yes No
Frequent diarrhea ……….. Yes No
Heartburn or indigestion . Yes No
Cramping or pain in abdomen…Yes No

Chest pain……………… Yes No
Shortness of breath with
walking or lying down Yes No
Difficulty walking
short distances………… Yes No
Heart attacks/Strokes…. Yes No
High Blood Pressure …… Yes No
Diabetes ……………… Yes No
Heart Murmur ………….. Yes No
Rheumatic Fever ……….. Yes No
Chronic Yeast infections… Yes No
Cancer ………………… Yes No

Do you have difficulty sleeping: Yes No
Do you drink soda? Yes No
If yes, how much do you drink in one day?
Do you crave carbohydrates? (Bread, pasta, cake, potatoes, rice, etc……) Yes No
If yes, do you feel better when you eat them? Yes No
Circle which answers applies if any to the following question.
If you go a long time without eating, do you feel:
shaky irritated experience fuzzy thinking get headaches
If any of these answers were circled does eating improve these symptoms? Yes No

List any current medications you are taking. (Include prescriptions, over the counter medications and supplements)____

Are you planning to get pregnant within the next 6 months? Yes No
Do you have any metal implants (pacemaker, rods, pins) Yes No
Are you allergic to any medications? Yes No If yes please list______________________
Are you allergic to any foods? Yes No If yes please list __________________________
Do you exercise? Yes No If yes what do you do? ______________________________

Family History: Please specify members of your family including extended family who have or have had the illnesses listed below:
Cancer: ____
Thyroid problems: ____
High Blood Pressure: ____
Diabetes: ____
Obesity: ____
Heart Disease: ____
Anorexia or Bulimia: ____