APPLICATION FOR WEIGHT LOSS AT

Enhanced Wellness

1600 Macy Drive, **Roswell** GA 30076
6395 McGinnis Ferry Rd #301, **Johns Creek** GA 30005
Phone: 770.552.7500 Fax: 888.819.9318
www.enhancedwellnesshealth.com

Welcome to Enhanced Wellness Clinics, LLC - where your health and weight loss goals always comes first. Please fill out this confidential Health Profile fully and accurately. The more we know, the better we will be able to help you. If you have any questions, do not hesitate to ask our staff for guidance.

Our Dietary consultation involves a health profile. The purpose of the health profile is not to establish a diagnosis, but rather to determine a client's health status in order to guide his or her weight loss plan. A client may be advised to seek medical advice based on his or her health profile.

If filled out away from our office, you can:
1. Bring it to your scheduled appointment
2. Fax it to (888) 819-9318

The purpose of our Doctor Supervised weight loss method is to help restore proper health and eliminate any excess toxins and/or adipose tissue (fat) via the healthy means of Ketosis. To also provide support and coaching for our clients for the ultimate success of reaching their weight goals.

Patient Information

Name _____ Sex: O M O F

Today's Date _____ Age _____ Birth Date _____

Your Height _____ Your Weight Now _____ Your Goal Weight _____

Street Address _____ Apt # _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____

Work Phone _____ Fax _____

Email _____

Best Place To Reach You (circle one) Home / Cell / Work / Email
May we leave a message for you? o Yes o No

Employer _____ Occupation _____

Length of Employment _____

Marital Status: o Single o Married o Separated o Divorced o Widowed

Name of Spouse/Significant Other _____

Spouses Occupation _____ Employer _____

Children & Ages _____

Please give your Drivers License to the Front Desk for proof of identity.

Most new patients are referred from friends & family - How did you hear about our office? *(please be specific)*: _____

_____

Important Health-Related Questions

Check "Yes" or "No" to the following conditions as they pertain to your medical history.

Yes	No	Condition
☐	☐	Severe Kidney Disease
☐	☐	Severe Liver Disease
☐	☐	Congestive Heart Failure
☐	☐	Active Cancer (or in remission less than 3 years)
☐	☐	Cardiac/Cardiovascular Event (within the last 6 months)
☐	☐	History of unstable Arrhythmia
☐	☐	Parkinson's Disease
☐	☐	Currently Pregnant or Nursing
☐	☐	Type 1 Diabetes (Juvenile)
☐	☐	Type 2 Diabetes (Adult Onset)
☐	☐	Taking Invokana (med. for Type II)
☐	☐	Allergic to Soy
☐	☐	Allergic to Gluten

Goals for my Weight Loss - *Please check all that apply.*

People start our weight loss method for a variety of reasons. Some simply want to lose weight while others want to perform other services to improve their health and / or appearance.

No matter what your reason is, your Doctor will weigh your needs and desires when making recommendations for care. Please check the type of program(s) you desire:

o Weight Loss only.

o Better overall health and well-being.

o To learn how to properly eat and take control of my metabolism.

o Weight Loss and Lose Inches with our Laser Lipo Treatments

o Weight Loss and Exercise Regiment via Pilates or MaxT3 Training

o Other: _____

 Patient Initials: _____ Date: _____

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Do you exercise? ☐ Yes ☐ No If yes, what kind? _____

How often? ☐ Daily ☐ Weekly ☐ Other: _____

Have you been on a diet before? ☐ Yes ☐ No

If yes, please specify which diet(s) and why you think it didn't work for you (e.g. too rigid, too much cooking, etc.):

1. _____
2. _____
3. _____

On a scale of 1 to 10, indicate what level of importance you give to losing weight with Ideal Protein's professionally supervised weight loss method: (circle one)

Least important: **1 2 3 4 5 6 7 8 9 10** Very important

Medical

Who is your primary care physician (family doctor)?

Please list any physicians you see and their specialty (refer to medical information for list of disorders):

Dr. _____ Specialty: _____ Patient since: _____ (MM/YY)

Dr. _____ Specialty: _____ Patient since: _____ (MM/YY)

Dr. _____ Specialty: _____ Patient since: _____ (MM/YY)

Diabetes

Do you have diabetes? ☐ Yes ☐ No If not, please skip to next section.

Which type?
- ☐ **Type I – Insulin-dependent (insulin injections only)**
- ☐ Type II – Non-insulin-dependent (diabetic pills)
- ☐ Type II – Insulin-dependent (diabetic pills and insulin)

Is your blood sugar level monitored? ☐ Yes ☐ No If so, how often? _____

If so, by whom? ☐ Myself ☐ Physician ☐ Other – please specify: _____

Do you tend to be hypoglycemic? ☐ Yes ☐ No

NOTE: If you are currently on a Sodium-Glucose Co-Transporter inhibitor (SGLT-2), do not start the weight loss method.

Cardiovascular Function

Have you had any of the following conditions?

- ☐ Arrhythmia (NPA - if not on Rx medication)
- ☐ Blood Clot (NPA)
- ☐ Coronary Artery Disease (NPA)
- ☐ Heart attack (NPC)
- ☐ Heart Valve Problem (NPA)
- ☐ Heart Valve Replacement (porcine/ mechanical) (NPA)
- ☐ Hyperlipidemia (High cholesterol/triglycerides)
- ☐ Hyperkalemia (High potassium) (NPA)
- ☐ Hypokalemia (Low potassium) (NPA)
- ☐ Hypertension (High blood pressure) (NPA)
- ☐ Pulmonary Embolism (NPA)
- ☐ Stroke or Transient Ischemic Attack (NPA)
- ☐ Congestive Heart Failure (NPC)

Please select one (if applicable):
- ☐ History of Congestive Heart Failure
- ☐ Current Congestive Heart Failure (NPC)

Have you ever had **any** type of heart surgery? ☐ Yes ☐ No

If so, which type? _____

Other conditions:

If you have answered yes to any of the above conditions, please give **all** dates of occurrence:

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Kidney Function

Have you had any of the following conditions:

- ☐ Kidney Disease (NPA) Date: _____
- ☐ Kidney Transplant (NPA)
- ☐ Kidney Stones Date: _____
- ☐ Do you have Gout? ☐ Yes ☐ No If so, since when? _____

If so, what medication has been prescribed?

If no, have you ever had Gout? ☐ Yes ☐ No If so, since when? _____

If yes to any of these events, please give dates of events. For multiple events please specify:

Liver Function

Have you ever had any liver conditions? ☐ Yes ☐ No Date: _____

If yes, please list: _____

Colon Function

Do you have any of the following conditions:

- ☐ Constipation
- ☐ Crohn's Disease
- ☐ Diarrhea
- ☐ Diverticulitis
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis

If yes to any of these conditions, please give dates of events. For multiple events please specify:

Digestive Function

Do you have any of the following conditions:

- ☐ Acid Reflux
- ☐ Celiac Disease
- ☐ Gastric Ulcer (NPA)
- ☐ Gluten intolerance
- ☐ Heartburn
- ☐ History of Bariatric Surgery (NPA)

If so, what type of bariatric surgery? _____

Ovarian/Breast Function

Do you currently have any of the following conditions:

- ☐ Amenorrhea
- ☐ Fibrocystic Breasts
- ☐ Heavy periods
- ☐ Hysterectomy
- ☐ Irregular periods
- ☐ Menopause
- ☐ Painful periods
- ☐ Uterine Fibroma

Ovarian/Breast Function (continued)

Date of last menstrual cycle: _____

Are you taking oral contraceptive pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

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Endocrine Function

Do you have thyroid problems?	☐ Yes	☐ No
If so, please specify:		
Do you have parathyroid problems?	☐ Yes	☐ No
If so, please specify:		
Do you have adrenal gland problems?	☐ Yes	☐ No
If so, please specify:		
Have you been told you have Metabolic Syndrome?	☐ Yes	☐ No

Neurological/Emotional Function

Do you have any of the following conditions:

☐ Alzheimer's disease	☐ Depression
☐ Anorexia (History of)	☐ Epilepsy (NPA)
☐ Anxiety	☐ Panic Attacks
☐ Bipolar Disorder	☐ Parkinson's disease
☐ Bulimia (History of)	☐ Schizophrenia

Other issues: _____

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Inflammatory Conditions

Do you have any of the following conditions:

- ☐ Chronic Fatigue Syndrome
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Psoriasis
- ☐ Other autoimmune or inflammatory condition
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Osteoarthritis
- ☐ Rheumatoid

Cancer

Do you have cancer? (NPC) ☐ Yes ☐ No

If so, what type and where is it located? _____

Have you ever had cancer? (NPC) ☐ Yes ☐ No

If so, what type and where was it located? ☐ Yes ☐ No

Is your cancer in remission? (NPC) ☐ Yes ☐ No

If so, how long have you been in remission? _____ (MM/YY)

General

Do you have any other health problems? ☐ Yes ☐ No

If so, please specify: _____

Allergies

Do you have any food allergies or sensitivities? ☐ Yes ☐ No

If so, please specify: _____

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Eating Habits

(Please provide honest answers so that we can help you)

BREAKFAST

Do you have breakfast every morning? ☐ Yes ☐ No ☐ Never

Approximate time: _____

Examples: _____

Do you have a snack before lunch? ☐ Yes ☐ No ☐ Never

Approximate time: _____

Examples: _____

LUNCH

Do you have lunch every day? ☐ Yes ☐ No ☐ Never

Approximate time: _____

Examples: _____

Do you have a snack before dinner? ☐ Yes ☐ No ☐ Never

Approximate time: _____

Examples: _____

DINNER

Do you have dinner every day? ☐ Yes ☐ No ☐ Never

Approximate time: _____

Examples: _____

Do you have a snack at night? ☐ Yes ☐ No ☐ Never

Approximate time: _____

Examples: _____

OTHER

Are you a vegan? ☐ Yes ☐ No

Strict vegans do not qualify due to too many dietary restrictions.

Are you a vegetarian? ☐ Yes ☐ No

How many glasses of **water** do you drink per day? _____ glasses per day

How many cups of **coffee** do you drink per day? _____ cups per day

Do you **smoke**? ☐ Yes ☐ No

If so, how many per day? _____ for how many years?

Do you drink alcohol? ☐ Yes ☐ No

If so, what and how often? _____

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The signatory client hereby recognizes the veracity of the information provided herein and that he/she has made an informed decision to start our clinic's weight loss program, if accepted through Enhanced Wellness Clinics. The client signed below also knows that perfroming our protocol claims no cure of any and all diseases, symptoms, or ailments. This signatory client also recognizes if any new symptoms present themselves during the weight loss program and they cannot contact our clinic, Enhanced Wellness Clinics, LLC in Roswell, Georgia; it is there responsibility to seek out the help of a local and qualified physician. I understand that results of weight loss may vary. I understand that I must take the Doctor recommended vitamins and minerals while I am performing this weight loss program. I also understand that if I stop taking the vitamins before the protocol is finished or if I do not follow the protocol, I may experience undesirable side effects.

If you have health problems not indicated on this health profile, please consult your local physician. I have answered all required information truthfully and to the best of my ability.

Print Name: _____ Signature: _____ Date: _____

NOTICE OF HIPAA PRIVACY PRACTICE

ENHANCED WELLNESS CLINICS is required to notify you, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which by law, or as dictated by - our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in a report folder labeled 'HIPAA' on the table in the reception area. Once you have read this notice, please sign at the bottom.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care.
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any available collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation.
5. Emergency- in the event of a medical emergency we may notify a family member.
6. For Public health and safety-in order to prevent, lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Spouses, household partners and other close family members.
12. Change of ownership- in the event this practice is sold the new owners would have access to your PHI

YOUR RIGHTS:

To receive an accounting of disclosures, paper copy of the comprehensive "Detail" Privacy Notice, request mailings to an address different than residence, request Restrictions on certain uses and disclosures and with whom we release information to, and request to inspect your records and receive one copy of your records at no charge. With notice in advance to request amendments to information, however like restrictions we are not required to agree to them.

QUESTIONS:

If you have further questions or wish to make a formal complaint about how we handle your health information please ask our receptionist to have our privacy coordinator contact you. **Note:** This office reserves the right to amend this notice of privacy practice at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I have reviewed, read, and understand the Authorization Form components above and received or have access to a copy of Enhanced Wellness Clinic's Patient Privacy Notice and understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding to the doctor. I understand that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient signature _____ Date _____

Patient Initials: _____ Date: _____