Patient Information
Weight Management Program

Please complete all pages as accurately as you can. If you need assistance please ask.
If possible, *please use a **blue ink pen** to make your form easier to read*.

Name: _____ Date: _____/_____/_____

Date of Birth: _____/_____/_____ Age: _____ Sex: ☐ Male ☐ Female

Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail: _____ Emergency contact: _____ Phone: _____

Social Security: _____ Drivers License: _____ State Issued: _____

Occupation: _____ Employer: _____ Phone: _____

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

Do we have your permission to send you newsletters, reports and/or special offers via postal mail or e-mail?
☐ Yes ☐ No

How did you hear about the Weight Management Program? _____

Primary Care Doctor: _____ Date last seen: _____

What other weight loss programs have you been on and how effective was the program?

_____

What level of commitment do you have to getting healthier?
☐ 0 – 25% ☐ 25 – 50% ☐ 50 – 75% ☐ 75 – 100%

What are your weight loss goals & what would you like to achieve with us?

_____

What is the general state of your health? ☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor
How would you rate your average stress level? ☐ Extreme ☐ Very High ☐ High ☐ Moderate ☐ Low

Do you have a past history or currently have constipation? (Defined as less than 1 bowel movement per day).
☐ Yes ☐ No

Do we have your permission once you reach your goal, to allow us to use your name as a testimonial?
☐ Yes ☐ No

The following are some reactions which are occasionally experienced by some individuals when losing weight. Please check yes or no if applicable with regards to your previous experience on weight loss programs and/or diets.

Nausea	☐ Yes	☐ No	Leg cramps	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Hunger pains	☐ Yes	☐ No
Sleeping problems	☐ Yes	☐ No	Plateaus	☐ Yes	☐ No
Weakness	☐ Yes	☐ No	Specific or general cravings	☐ Yes	☐ No
Tiredness	☐ Yes	☐ No	Hair thinning	☐ Yes	☐ No
Light headedness	☐ Yes	☐ No	Absence of menstrual period	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No

List any other reactions you might have had: _____

Medications

Please list all **prescription medications**: (e.g., Prozac, Atenolol, Lipitor, etc.)

Please list all **over the counter medications**: (e.g., Tums, Advil, Tylenol, Aspirin, etc.)

Please list all **vitamins, minerals, herbs** and/or additional nutritional supplements:

Past and/or Current Medical History

☐ Measles	☐ Tuberculosis	☐ Hepatitis	☐ Digestive Disorders
☐ Mumps	☐ Venereal Disease	☐ Diabetes	☐ Hormonal Disorders
☐ Chickenpox	☐ Epilepsy	☐ High Blood Pressure	☐ Reproductive Disorders
☐ Whooping cough	☐ Cancer	☐ Low Blood Pressure	☐ Osteoporosis
☐ Scarlet Fever	☐ Glaucoma	☐ Asthma	☐ Anemia
☐ Diptheria	☐ Mitral Valve Prolapse	☐ Ulcer	☐ Chronic Fatique
☐ Smallpox	☐ Stroke	☐ Heart Disease	☐ Fibromyalgia
☐ Polio	☐ Hernia	☐ Thyroid Disease	☐ Headaches
☐ Pneumonia	☐ Bleeding tendency	☐ Kidney Disease	☐ Neck pain
☐ Rheumatic Fever	☐ AIDS or HIV	☐ Lung Disease	☐ Back pain

Please list any medical problems or conditions that are not listed above. _____

Patient Authorization

I understand the Weight Management Program is non-refundable.

I also understand that my Weight Management Program is not transferable and
must be completed within 5 weeks of starting the program.

Important Warning
The Weight Management Program is very extensive and cannot be reproduced in any way.

Dr. Brian N Hardy cannot be held responsible for any complications or problems arising from the unauthorized use of this program.

I also understand that I will undertake the Weight Management Program entirely at my own risk and that Dr. Brian N. Hardy and his staff will endeavour to take all due care.

The following is your responsibility and extremely important to the outcome of the amount **of healthy weight** you lose.

- Keep your scheduled appointments each week.
- Take the recommended amount's of all supplements that you are given.
- If you fail to continue to keep your weekly appointments you will be terminated from care with no refund.

The contact information, health history, and other information that I provided on my intake form are complete and accurate.

_____ _____
Signature of Patient or Guardian Date