Patient Intake Form(s)

Patient Name: (Last)_____(First)_____(MI)_____
Patient Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ mobile/Cellular: _____
Email: _____ preferred contact method: email / phone
Birth date: _____Age: _____Sex: M F
Country of Birth: _____ Country of Parents' Birth: _____
Education: Elementary High School/Tech School 2-yr College 4-yr College Grad. School (Circle Highest Level)

Employment Information:
Patient Employer: _____ Occupation: _____
Employer Address: _____
City: _____ State: _____ Zip_____
Work phone No: _____Ext. _____
Social Security: _____Drivers License: _____

In Case of Emergency:
Name: _____Relationship: _____ Phone:_____
Patient's Spouse: _____ Phone:_____
Family Physician: _____ Phone:_____
Referred by: _____

Past History: (Please check if you have had any of the following):

☐ Allergies, Type: _____ ☐ Birth defects or abnormalities
☐ Exposed to tuberculosis ☐ Measles ☐ Scarlatina ☐ Influenza
☐ Mumps ☐ Diphtheria ☐ Rheumatic
☐ Fever German Measles (3 day) ☐ Polio ☐ Whooping Cough
☐ Frequent Colds ☐ Chickenpox ☐ Tonsillitis ☐ Scarlet Fever
☐ Pneumonia ☐ Diabetes:Type: _____
☐ Cancer, Type:_____ ☐ Other Diseases _____
☐ Operations:(dates) _____
Current Medications (vitamins, birth control pills): _____
Any mood altering or depression medication:_____
Allergies to medicines, foods, etc_____

Family History:
Father: Health _____ Age _____ Deceased _____ at age _____ Cause _____
Mother: Health _____ Age _____ Deceased _____ at age _____ Cause _____
# of siblings:_____ # living_____ #deceased: _____ Cause _____

Family Diseases: Check diseases known in your blood relatives (not yourself)

☐ High blood pressure ☐ Allergy ☐ Heart trouble ☐ Anemia
☐ Migraine ☐ Bleeding (abnormal) ☐ Dropsy ☐ Epilepsy
☐ Strokes ☐ Cancer ☐ Diabetes ☐ Nervous breakdown
☐ Kidney disease ☐ Syphilis or (bad blood) ☐ Suicide ☐ Obesity
☐ Arthritis ☐ Rheumatic ☐ Fever
☐ Other _____

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Examinations:

Date of last physical examination _____ Reason:_____
Hospitalizations _____ Dates _____ Reason:_____
X-Rays: Chest _____Stomach _____ Gallbladder _____ Kidney _____Colon _____
Other _____Date of last laboratory tests:_____
Electrocardiogram (heart tracing) _____ Date of last pap (cancer smear): _____

Do you now have or have had any of the following?

☐ Itching ☐ Eczema ☐ Hives ☐ Joint pains ☐ Muscle aches
☐ Arthritis ☐ Limitation of motion ☐ Backache ☐ Leg pains ☐ Heel Pains
☐ Pain or stiffness (neck) ☐ Goiter ☐ Swelling, enlarged glands
☐ Asthma ☐ Lung disease ☐ Raise sputum ☐ Emphysema Bronchitis
☐ Heart trouble ☐ High blood pressure ☐ Shortness of breath ☐ Palpitation or fluttering
☐ Chest pain ☐ Lips or nails turn blue ☐ Tire easily ☐ Swelling of ankles
☐ Indigestion ☐ Nausea or vomiting ☐ Abdominal pain ☐ Gas or bloating ☐ Diarrhea
☐ Hard bowel movements ☐ No. of bowel movements - daily _____ ☐ Colitis
☐ Jaundice ☐ Hemorrhoids (piles) ☐ Bleeding or black stools ☐ Hernia
☐ Urinary System ☐ Kidney disease ☐ Bladder disease ☐ Kidney stones
☐ Painful urination ☐ Pus or blood in urine ☐ Albumen or sugar in urine
☐ Dribbling of urine ☐ Varicose veins ☐ Nervousness or anxiety
☐ Trouble sleeping ☐ Headaches ☐ Bored or depressed ☐ Nervous breakdown
☐ Fainting ☐ Convulsions ☐ Numbness ☐ Loss of consciousness
☐ Neuritis or Neuralgia ☐ Paralysis

Menstrual History:

Menstruation began at age:_____28 day cycle? _____ If no, how many days? _____
Duration of bleeding:_____Pain with periods?_____
Amount of flow : Light _____ Med. _____Heavy _____
Date of 1st day of last: _____menstrual period:_____
Bleeding between periods:_____Bleeding after intercourse:_____
Irritation or discharge:_____Itching or burning _____

Weight History:

When did you first become overweight? (your age then)_____(year) _____
How did your weight gain start? Describe any circumstances: _____
_____
What do you think is the cause of your weight problem:_____
_____
Your present weight: _____ your weight goal: _____height: _____
What was your highest weight? (excluding pregnancy) _____your age then _____# of years ago:_____
What was your lowest weight? _____your age then _____# of years ago:_____
Have you ever stayed the same weight for 10 years or more? Yes/ No
Have you attempted to lose weight before? _____ most lbs lost:_____how long it took:_____
Describe previous methods of weight loss (e.g. diets, pills, injections, hypnosis, acupuncture) and describe your results:___
_____
_____

Where and when do you do most of your overeating?_____
_____
Please make any comments that you think might be helpful:
_____
_____

Do you currently have any medical concerns? Please List:_____
_____
_____

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Financial and Prescription Policy

Thank you for selecting Thrive Health Solutions and/or its medical staff for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard, Discover, American Express, checks and cash.

I understand that Thrive Health Solutions is a 'cash practice'; therefore, my insurance will not necessarily cover any procedure or payment toward any of my sessions. I agree to cancel/or reschedule my sessions at least 48 hours in advance of existing scheduled appointments by calling or leaving a detailed message to Thrive Health Solutions at 303-790-8446. Any missed or cancelled appointments may be subject to a cancellation fee or be subject to the full cost of the missed treatment.

I understand that I am voluntarily participating in a weight loss program involving behavioral modification, dieting and daily hCG and/or lipotropic self injections. I understand there are required medical evaluations and agree to pay a $150 doctor exam /medical services fee for my medical services for the program. I also agree to pay a $150 consultation fee, which will be waived should I elect to participate in the program. I understand the results are not guaranteed, may vary and that it is necessary for me to follow the required diet plan in conjunction with hCG injections to achieve my desired weight loss goal.

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand and agree there are no refunds once services have been provided. I further agree in the event of non-payment, to bear the cost of collection, and/or Court cost and reasonable legal fees, should this be required. I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees, court costs and accrued interest.

Prescription Acknowledgement:
Because your health can vary over time, Thrive Health Solutions only honors prescriptions for ninety (90) days after the original date the prescription is written, unless our physician(s) disapprove continued treatment. After ninety (90) days another consultation/exam with our doctor is required.

I have read and understand all of the above and have agreed to these statements and terms.

All Statements on this patient intake form are accurate and true to the best of my knowledge. I understand that treatments will be based on the information provided herein. If I willingly withhold knowledge from my treating physician, I accept full liability from any consequences arising there from.

Patient/Client Signature: _____

Patient/Client Name (Print): _____ **Date:** _____

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Statement of Privacy Practices

Our office is dedicated to protect the privacy rights of our clients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information
We use and disclose the information we collect from you only as allowed by the Health Insurance Probability and Accountability Act and state law. This personal health information will never be otherwise given to anyone, even family members, without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future clients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information
We will only request personal information needed to provide our standard of quality healthcare, implement payment activities, conduct normal healthcare practice operations, and comply with the law. This may include your name, address, telephone number(s), social security #, employment data, medical history, health records,etc.. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information
As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental official under certain circumstances. We will not use your protected health information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail/answering machine messages, postcards, newsletters and special events.

Client Rights
You have the right to request copies of your healthcare information; to request copies in various formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for use other than stated above. All such requests must be in writing. We may charge you for copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a client at Thrive Health Solutions. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

Patient/Client Signature: _____ **Date:** _____

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hCG WEIGHT LOSS PROGRAM
INFORMED CONSENT

I request injections of hCG along with strict dietary restrictions for the purpose of weight loss. I understand that as part of the program, I will be given a limited physical, orientation to the program with supporting materials and I will be instructed on how to administer the injections myself. I understand that initial blood tests will be necessary to rule out any conditions that would disqualify me from the program. I will obtain these from my own physician or have them ordered through Thrive Health Solutions at an additional cost.

I understand hCG is not FDA approved for weight loss as this application is considered "off-label use." I understand there is no medical evidence to support the use of hCG for this purpose. I agree that I am and will be under the care of another medical provider for all other conditions. Thrive Health Solutions and/or its medical staff can work in conjunction with, but cannot replace, my regular primary care physicians, such as general practitioners or other specialists in family medicine or internal medicine. I understand Thrive Health Solutions and/or its medical staff can only prescribe hCG and lipotropic medication necessary for this treatment and all other health matters should be through my regular physician(s).

Prior to my treatment, I have fully disclosed any medical conditions or diseases such as pregnancy, trying to get pregnant, breastfeeding, history of gallbladder disease, diabetes, autoimmune diseases, HIV, heart disease, liver disease, kidney disease, uncontrolled high blood pressure, seizure disorders, blood disorder (anemia, thalessemia, hemophilia, etc.) emphysema or asthma, and any history of stroke or cancer. These contraindications have been fully discussed with me.

If I fail to disclose any medical condition that I have, I release the doctor and facility from any liability associated with this procedure.

Initials:_____

While hCG is generally free of negative side effects, there is the rare possibility of the following:

- Ovarian Hyper-stimulation Syndrome (OHSS) – Over stimulation of the ovaries causing production of many ova (eggs) in women, which may be a serious and potentially life-threatening condition in women.
- Arterial Thromboembolism - a potentially serious condition
- Blood clots
- Risk of multiple pregnancies (twins, triplets, quadruplets, etc.)
- Acne
- Changes in mood
- Irritation or skin rash in area of use

I understand hCG treatments may involve these risks and other unknown risks:

Initials:_____

I understand that use of hCG is absolutely contraindicated during pregnancy and breastfeeding. I understand that it is my responsibility to inform Thrive Health Solutions and/or its medical staff if I am pregnant, if I am trying to become pregnant or if I become pregnant during the course of these treatments.

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Initials:_____

I understand that hCG is used in infertility treatments, and therefore, I may have an increased chance of pregnancy while on hCG. Multiple birth control methods should be used while on hCG. However, hCG is contraindicated for women using IUD for birth control. I agree to use condoms and/or abstinence as birth control method for the duration of the treatment.

Initials:_____

I agree to immediately report any problems that might occur to my medical provider during the treatment program. I further understand that not complying with the dosage recommendations and dietary restrictions could increase risks and alter my results from the program. If I do not follow these recommendations and restrictions, I agree to release the doctor and facility from any liability arising as a result of this.

Initials:_____

I understand that I may quit the program at any time, however there are no refunds once services have been provided. While adverse side effects or complications are not expected, in the event that an illness does occur, I understand that I need to contact Thrive Health Solutions and/or its medical staff immediately. If I experience an emergency situation, I understand that I need to go to an emergency facility.

Initials:_____

I understand that if there are any changes in my medical history or there are any changes in my medications or any other changes relevant to this procedure, I will advise Thrive Health Solutions and/or its medical staff at that time.
PHOTOGRAPHS: I give permission for photographs of the treated area(s) to be used by Thrive Health Solutions and/or its medical staff for information kept in my file, and/or teaching purposes. Photographs will not be used for promotional purposes without a signed model release form. Complete patient confidentiality will be maintained at all times.

Initials:_____

I have read and fully understand the above terms. All my questions have been addressed to my satisfaction. I agree to hold harmless; Thrive Health Solutions, its owners, physicians, clinicians and staff harmless from any and all suits, demands, liabilities, claims, actions, expenses, losses and damages of any kind or nature whatsoever, including, without limitation, general, direct, special, indirect and consequential damages and costs of litigation both during and after my participation in this program. I agree to release the doctor and the facility from any liability associated with this procedure. In the event a dispute arises over the outcome of the procedure, I consent solely to arbitration as a legal means of settlement.

I understand that any medical treatment may involve risks as well as the proposed benefits. I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand 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.

Patient/Client Signature: _____

Patient/Client Name (Print): _____ **Date:** _____

Practitioner Signature:_____

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LIPOTROPIC INJECTIONS INFORMED CONSENT

I have been informed of the following:

- While all components generally have no side effects, doses must be taken at regular intervals. The injections are only effective temporarily. As soon as the effect of these drugs wear out, the body starts returning to normal.
- Some redness, minor discomfort, small bruising and bleeding at the injection site may occur. This will usually dissipate in a minimal amount of time.
- Some people have experienced allergic reactions to the injections.
- Potential side effects include stomach upset and urinary problems due to the strain the injections place on the kidneys.
- It has been reported that B12 can cause peripheral vascular thrombosis, itching, and a feeling of swelling in the body.
- Unexplained pain may develop in unrelated parts of the body. Some people have experienced joint pains.
- Lipotropic injections change the function of the digestive system temporarily. This can result in temporary exhaustion.
- Weight loss can be inconsistent from one week to the next. There can be no guarantees as to the timetable of a weight loss program.
- Too much Methionine and Adenosine Monophosphate can potentially accumulate in the body and have the side effect of boosting the metabolic rate too high. If any abnormal heart racing occurs, I will contact my medical provider immediately.
- Vitamin B12 is contraindicated in Leber's hereditary optic neuritis.

I will inform my practitioner of any changes in my medical history, current medications, and/or any changes relevant to this procedure prior to any future treatments.

I have read the above and I agree to accept the risk of the procedure. All my questions have been answered to my satisfaction. I agree to release the facility and the medical practitioner from any liability arising from the procedures. I consent solely to arbitration as a legal means of settlement.

Patient/Client Signature: _____

Patient/Client Name (Print): _____ **Date:** _____

Practitioner Signature:_____

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B12 Injections Informed Consent

Vitamin B-12 helps maintain good health and has been shown to be beneficial in helping to: Reduce stress, fatigue, improve memory and cardiovascular health, and maintain a a good body weight. It can also assist the body in converting proteins, fats and carbohydrates into energy and is necessary for healthy skin and eyes.

B12 Injections are better absorbed by the body since they go directly into the blood stream. Alternatives to B12 injections are Oral Vitamins, B12 Patch, Lozenges, Liquid drops and Nasal Spray

B12 Injections common side effects include but are not limited to:

1. Risks: I understand there is risk of mild diarrhea, upset stomach, nausea, a feeling of pain and a warm sensation at the site of the injection, a feeling, or a sense, of being swollen over the entire body, headache and joint pain
2. If any of these side effects become severe or troublesome I will contact my physician immediately
3. I understand that although rare Vitamin B12 injections can result in serious side effects. Although this is a relatively rare occurrence, anyone taking vitamin B12 injections should be aware of the possibility. Uncommon side effects are much more serious than the common side effects of B12 injections, and such side effects should be reported to a physician to be evaluated for seriousness. Uncommon but dangerous side effects may include:
    - rapid heartbeat
    - chest pain
    - muscle cramps and weakness
    - difficulty breathing and swallowing
    - dizziness
    - confusion
    - tight feelings in the chest
    - hives, skin rashes
    - shortness of breath when there is no physical exertion and unusual wheezing and coughing.
4. Before starting vitamin B12 injections I will make sure to tell my Physician if I am pregnant, lactating or have any of the following conditions.
    - Leber's Disease
    - Kidney disease
    - Liver disease
    - An infection
    - Iron deficiency
    - Folic acid deficiency
    - Receiving any treatment or taking any medication that has an effect on bone marrow
    - An allergy to cobalt or any other medication, vitamin, dye, food or preservative
5. I understand that certain herbal products, vitamins, minerals, nutritional supplements, prescription and non prescription medications may result in side effects when they interact with the B12 Injection.
6. Treatments: Can be once a month, Once a week, Twice a week and will be determined by the provider.

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 B12 Injections with the above understood. I hereby release the doctor, the person injecting the B12 and the facility from liability associated with this procedure.

Patient/Client Signature: _____ **Date:** _____

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PHENTERMINE WEIGHT LOSS PROGRAM
INFORMED CONSENT

I request the use of Phentermine, along with strict dietary restrictions for the purpose of weight loss. I understand that as part of the program, I will be given a limited physical, orientation to the program with supporting materials and I will be instructed on how to administer Phentermine myself. I understand that initial blood tests may be necessary to rule out any conditions that would disqualify me from the program. I will obtain these from my own physician or have them ordered through Thrive Health Solutions at an additional cost I understand there is no guarantee for the effectiveness of Phentermine. I agree that I am and will be under the care of another medical provider for all other conditions. Thrive Health Solutions and/or its medical staff can work in conjunction with, but cannot replace, my regular primary care physicians, such as general practitioners or other specialists in family medicine or internal medicine. I understand Thrive Health Solutions and/or its medical staff can only prescribe Phentermine and medication necessary for this treatment and all other health matters should be through my regular physician(s).

Prior to my treatment, I have fully disclosed any medical conditions or diseases such as history of gallbladder disease, diabetes, autoimmune diseases, HIV, heart disease, liver disease, kidney disease, uncontrolled high blood pressure, seizure disorders, blood disorder (anemia, thalessemia, hemophilia, etc.) emphysema or asthma, and any history of stroke or cancer. These contraindications have been fully discussed with me. Further contraindications are outlined below. If I fail to disclose any medical condition that I have, I release the doctor and facility from any liability associated with this procedure.

Initials:_____

Contraindications and Warnings –
Patients with the following should not use Phentermine:

- An allergy to Phentermine
- Those who have taken a monoamine oxidase inhibitor (MAO) within the last 14 days
- Have advanced arteriosclerosis, cardiovascular disease, moderate to severe hypertension, hyperthyroidism, or glaucoma
- Are in an agitated state or have a history of drug or alcohol abuse
- Women who are nursing, pregnant, or plan on becoming pregnant

Patients with the following should take special precautions and consult their doctor before using Phentermine:

- Allergies to medicines, foods, or other substances
- Those who have diabetes may need a larger dose of insulin while taking phentermine
- Have a brain or spinal cord disorder, hardening of the arteries, high blood pressure, diabetes, or high cholesterol or lipid levels

Side Effects
While Phentermine is generally free of negative side effects, there is the possibility of the following:

- Dry mouth
- Unpleasant taste
- Heartburn
- Skin Rash or Itching
- Diarrhea
- Constipation
- Stomach Pain
- Lactic acidosis
- Nausea/ Vomiting
- Fatigue
- Hypertension
- Insomnia or Restlessness
- Heart Attack
- Stroke
- Aneurism

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Less common side effects include:

- Convulsions (Seizures)
- Erectile Dysfunction
- Depression
- Panic attacks
- Fever
- Hallucinations
- Tremors or shaking
- Fainting
- Overactive reflexes

I understand Phentermine treatments may involve these risks and other unknown risks:

Initials:_____

I understand that use of Phentermine is absolutely contraindicated during pregnancy and breastfeeding. I understand that it is my responsibility to inform Thrive Health Solutions and/or its medical staff if I am pregnant, if I am trying to become pregnant or if I become pregnant during the course of these treatments.

Initials:_____

I agree to immediately report any problems that might occur to my medical provider during the treatment program. I further understand that not complying with the dosage recommendations and dietary restrictions could increase risks and alter my results from the program. If I do not follow these recommendations and restrictions, I agree to release the doctor and facility from any liability arising as a result of this.

Initials:_____

I understand that I may quit the program at any time. While adverse side effects or complications are not expected, in the event that an illness does occur, I understand that I need to contact Thrive Health Solutions and/or its medical staff immediately. If I experience an emergency situation, I understand that I need to go to an emergency facility.

Initials:_____

I understand that if there are any changes in my medical history or there are any changes in my medications or any other changes relevant to this procedure, I will advise Thrive Health Solutions and/or its medical staff at that time.

PHOTOGRAPHS: I give permission for photographs of the treated area(s) to be used by Thrive Health Solutions and/or its medical staff for information kept in my file, and/or teaching purposes. Photographs will not be used for promotional purposes without a signed model release form. Complete patient confidentiality will be maintained at all times.

Initials:_____

I have read and fully understand the above terms. All my questions have been addressed to my satisfaction. I agree to hold harmless; Thrive Health Solutions, its owners, physicians, clinicians and staff harmless from any and all suits, demands, liabilities, claims, actions, expenses, losses and damages of any kind or nature whatsoever, including, without limitation, general, direct, special, indirect and consequential damages and costs of litigation both during and after my participation in this program. I agree to release the doctor and the facility from any liability associated with this procedure. In the event a dispute arises over the outcome of the procedure, I consent solely to arbitration as a legal means of settlement.

I understand that any medical treatment may involve risks as well as the proposed benefits. I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand 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.

Patient's Name Printed:_____

Patient's Name Signed:_____Date:_____

Provider's Signature:_____Date:_____

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