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Weight Loss Intake Form

Name: _____ Date of Birth _____

ALLERGIES (Please list any food, drug, or medication hypersensitivities or allergies you experience. Please include reaction.)

_____

_____

Sulfa Allergy_____ Soy Allergy_____

Topical Anesthetic Allergy___✔___ Specify_____

MEDICATIONS

Current medications (vitamins, birth control pills) _____

_____

Mood-altering or depression medication _____

SKIN ASSESSMENT

Do you have any of the following concerns? (Check all that apply.)

___Fine Lines	___Deep Wrinkles	___Under eye Circles	___Sagging Skin
___Dark Spots	___Rough skin texture	___Large pores	___Sagging cheek bones
___Stretch marks	___Scars (acne or surgical)	___None	___Other:

MENSTRUAL / BIRTHING HISTORY

Is it possible you may be pregnant? Yes____ No____ If "Yes" How far along? _____

Last Menstrual Cycle_____	Age of first Menses_____	Itching or burning	____Yes ____No
# of Pregnancies_____	# of Days of Menses_____	Bleeding between periods	____Yes ____No
# of Miscarriages_____	Length of Cycle_____	Bleeding after intercourse	____Yes ____No
# of Live Births_____	# of Abortions_____	Irritation or discharge	____Yes ____No

FAMILY HISTORY (Check all health conditions that apply.)

	Father	Mother	Brother(s)	Sister(s)
Age (if living)				
Health (G=Good / P=Poor)				
Cancer				
Diabetes				
Heart Disease				
High Blood Pressure				
Stroke				
Mental Illness				
Asthma/Hay Fever/Hives				
Kidney Disease				
Age (at Death)				
Cause of Death				

GENERAL HEALTH

When and where did you last receive health care?

_____

For what reason? _____

Do you have any infectious diseases? Yes____ No____

If "Yes" Please Identify _____

What was your most recent blood pressure reading? _____/_____ Date taken ___/___/___

Do you currently have any medical concerns? Please list_____

_____

Have You Been Able To Follow Prescribed Medications/Treatments? Yes____ No____

If "No" why not? _____

Have you been diagnosed with or had any of the following conditions (past or present)?
Please check all that apply.

___Hepatitis	___Headaches	___Scoliosis	___Brain Fog	___Neck Pain
___Fatigue	___Back Pain	___Fever	___Shoulder Pain	___Leg Pain
___Insomnia	___Heart Murmur	___Depression	___Diabetes	___Spasms/Cramps
___Hot Flashes	___Tendonitis	___Asthma	___Chest Pain	___Osteoporosis
___Dizziness	___Anxiety	___Heart Disease	___Abdominal Pain	___Stroke
___Cancer	___Blood Clots	___Gas/Bloating	___High Blood Pressure	___Thyroid Dysfunction
___Epilepsy/ seizures	___Numbness/ tingling	___Constipation/ Diarrhea	___Shortness of Breath	___Arthritis/Stiff/ Painful Joints
___Rash/ skin problems	___Bladder/ Kidney Disease	___Sciatica/ Shooting pain		

Please provide more explanation about all that you checked.

_____

_____

Have you been diagnosed with or had any of the following digestive disorders (past or present)?

Please check all that apply.

___Nausea	___Vomiting	___Diarrhea	___Blood in stool
___Bloating/Gas	___ABD Distention	___Constipation	___Incomplete Evacuation
___Small Round Stool	___Hard Stool	___ABD cramping	___Significant Residual When Wiping

DIGESTIVE HEALTH / BOWEL MOVEMENT (BM) CHARACTERISTICS

Number of BM times per day: ___1 ___2 ___3 ___4

If don't typically have a daily BM how often do you evacuate?

___1-2 times per week ___3-4 per week ___5-6 per week ___less than once a week

Does it feel like there is more feces stuck in you after having bowel movement? ___Yes ___No

Do you eat a diet low in fiber? ___Yes ___No

Does your diet include a lot of meat/cheese or processed foods? ___Yes ___No

Do you suffer from incontinence? ___Yes ___No

Do you experience pain upon defecation? ___Yes ___No

Do you experience blood in your stool? ___Yes ___No

Do you have hemorrhoids? ___Yes ___No

When was your last bowel movement? _____

What BM interventions do you use? ___None ___Laxatives ___Enemas ___Other_____

EXAMINATIONS HISTORY

Date of last physical examination _____ Reason _____

Hospitalization Dates and Reasons_____

X-Rays: ___Chest ___Stomach ___Gallbladder ___Kidney ___Colon ___Other_____

Date of last laboratory tests_____

Data of last electrocardiogram (heart tracing) _____

Date of last pap (cancer smear) _____

WEIGHT HISTORY

When did you first become overweight? (Year)_____ (Your age then) _____

How did your weight gain start? Describe the circumstances _____

_____

What do you think is the cause of your weight problem? _____

_____

Your present weight_____ Your weight goal_____ Your height _____

What was your highest weight? (excluding pregnancy) _____ Your age then_____

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? ___Yes ___No

Most lbs lost_____ How long it took_____

Describe your previous weight loss methods (e.g. diets, pills, injections, hypnosis, acupuncture) and results

_____

_____

_____

ENERGY AND IMMUNITY

Do you have any of the following concerns? (Check all that apply.)

___Fatigue ___Slow Wound Healing ___Chronic Infections

___Lyme Disease ___Chronic Fatigue ___Candida / Yeast Infections

EMOTIONAL/PSYCHIATRIC

Do you have any of the following concerns? (Check all that apply.)

___Mood Swings ___Nervousness ___Mental Tension

___Irritability ___Depression ___Grief

HEAD, EYE, EAR, NOSE, THROAT

Do you have any of the following concerns? (Check all that apply.)

___Impaired Vision ___Eye Pain/ Strain ___Glaucoma ___Glasses/Contacts

___Impaired Hearing ___Ear Ringing ___Earaches ___Headaches

___Nose Bleeds ___Frequent Sore Throats ___Teeth Grinding ___TMJ/Jaw Problems

___Tearing/Dryness ___Sinus Problems ___Hay Fever

RESPIRATORY

Do you have any of the following concerns? (Check all that apply.)

___Pneumonia ___Frequent Common Colds ___Difficulty Breathing

___Pleurisy ___Asthma ___Tuberculosis

___Persistent Cough ___Emphysema ___Shortness of Breath

CARDIOVASCULAR

Do you have any of the following concerns? (Check all that apply.)

___Heart Disease ___Chest Pain ___Swelling of Ankles ___High BP Palpitations

___Fluttering ___Stroke ___Bruising ___Heart Murmurs

___Rheumatic Fever ___Varicose Veins ___Abnormal Bleeding ___Pain in Calves

GASTROINTESTINAL

Do you have any of the following concerns? (Check all that apply.)

___Ulcers ___Changes In Appetite ___Nausea/Vomiting ___Epigastric Pain

___Heartburn ___Gallbladder Disease ___Liver Disease ___Hemorrhoids

___IBS ___Hepatitis A, B or C ___Abdominal Pain ___Passing Gas

___Diverticulitis

GENITO-URINARY TRACT

Do you have any of the following concerns? (Check all that apply.)

___Kidney Disease ___Painful Urination ___Frequent UTI

___Kidney Stones ___Impaired Urination ___Blood in Urine

___Frequent Urination ___Frequent Urination at Night ___Heavy Flow

FEMALE REPRODUCTIVE / BREASTS

Do you have any of the following concerns? (Check all that apply.)

___Irregular Cycles ___Breast Lumps/ Tenderness ___Difficulty Conceiving

___Vaginal Discharge ___Premenstrual Problems ___Bleeding Between Cycles

___Menopausal Symptoms ___Clotting ___Heavy Flow

___Nipple Discharge ___Painful Periods

MALE REPRODUCTIVE

Do you have any of the following concerns? (Check all that apply.)

___Erectile Dysfunction ___Prostate Problems ___Testicular Pain/Swelling ___Penile Discharge

MUSCULOSKELETAL

Do you have any of the following concerns? (Check all that apply.)

___Neck/Shoulder ___Muscle Spasms/Cramps ___Arm Pain ___Upper Back Pain

___Lower Back Pain ___Lower Back Pain ___Leg Pain ___Joint Pain

NEUROLOGIC

Do you have any of the following concerns? (Check all that apply.)

___Vertigo/Dizziness ___Paralysis ___Numbness/Tingling ___Loss of Balance ___Seizures/Epilepsy

ENDOCRINE

Do you have any of the following concerns? (Check all that apply.)

___Hypothyroid ___Hypoglycemia ___Hyperthyroid

___Diabetes ___Night Sweats ___Feeling Hot or Cold

LIFESTYLE

Do you typically eat at least three meals per day? ___Yes ___No

If "No" why not?_____

Describe your exercise routine_____

Describe your spiritual practice_____

How many hours per night do you sleep? _____ Do you wake rested? ___Yes ___No

Level of education completed: ___High School ___Bachelors ___Masters ___Doctorate ___Other

Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy work? ___Yes ___No Why or Why Not? _____

_____

In the past or present, have you:

- used nicotine? ___Yes ___No If "Yes" what form?_____

  Amount_____ Frequency_____
- used alcohol? ___Yes ___No If "Yes" what form?_____

  Amount_____ Frequency_____
- used recreational drugs? ___Yes ___No If "Yes" what form?_____

  Amount_____ Frequency_____

Have you experienced any major traumas? ___Yes ___No

If "Yes" please explain: _____

_____

How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

List your interests and hobbies_____

_____

I _____ (patient name) acknowledge and understand that:

1) Aleksandr Benji FNP and Aesthetic Solutions NY is NOT my primary Medical Doctor;

2) All medical decisions regarding any current or future health conditions should be addressed by my primary care physician;

3) Aesthetic Solutions NY serves as only a resource for general well-being and preventive medicine and does NOT treat any existing illness;

4) All supplied information is accurate and forthcoming;

5) I have informed my primary care physician about services I am to receive at Aesthetic Solutions NY and he/she has no objections to such services.

6) I have not been rushed into making any decisions and I have had ample opportunities to ask Aleksandr Benji FNP and my primary care physician questions prior to receiving any treatment.

7) I acknowledge that Aleksandr Benji FNP/ Aesthetic Solutions NY does not provide any promises or guarantees that the treatments I am to receive will be effective in helping to improve my current health conditions and that in coming to Aesthetic Solutions NY, I had previously made a decision independent of Aesthetic Solutions NY to try the services offered at Aesthetic Solutions NY.

8) I understand that there are NO REFUNDS and state that I can afford the services I am seeking and that I have not been made any promises as to the results or effectiveness of such services/treatments.
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_____ _____
PATIENT SIGNATURE DATE

_____
PRINT NAME