SOLÉ MEDICAL SPA WEIGHT MANAGEMENT CENTER
A DIVISION OF
FAMILY PRIMCARE, LLC

We would like to thank you for choosing Solé Medical Spa Weight Management Center for your needs. Below are a few things you will need to know before your first visit:

- Please bring your insurance card (the metabolic rate test will be billed to insurance, no charge to patient for this test, if not covered by insurance).
- Wear loose fitting clothes – you will be weighed and measurements taken
- **WE SUGGEST A FOUR HOUR FAST (NOTHING BUT WATER) PRIOR TO YOUR FIRST VISIT TO OBTAIN AN ACCURATE METABOLIC RATE RESULT.** We can still do the metabolic test but it is more accurate if fasting.
- Print out and complete the paperwork from the web to bring with you to your visit. If unable to print the forms, please arrive for your appointment at least 30 minutes early to fill out paperwork.

IN ORDER TO CONTROL OUR COST OF BILLING, WE REQUEST THAT OFFICE VISTS BE PAID AT THE TIME SERVICE IS RENDERED. WE WOULD RATHER CONTROL OUR BILLING COSTS THAN BE FORCED TO RAISE OUR FEES.

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CONSENT FOR TREATMENT

I authorize Solé Medical Spa Weight Management Center a division of Family PrimeCare, LLC and the physician assigned to furnish the medical and/or surgical treatment or tests that are deemed appropriate by the physician for the patient whose name appears on this form.

RELEASE OF INFORMATION

__ Yes __ No I authorize Solé Medical Spa Weight Management Center a division of Family PrimeCare, LLC and all physicians to release any information, reports, copies of records necessary to process insurance, etc., to other referral Physicians; my personal physician or attending physician; Blue Cross Blue Shield, Medicare, Medicaid, or other health insurance companies to complete the patient's claim(s); and the appropriate governmental agency of the United States as such information may be required by Federal Law.

ASSIGNMENT OF INSURANCE BENEFITS

__ Yes __ No I hereby authorize and direct payment to Solé Medical Spa Weight Management Center a division of Family PrimeCare, LLC and to all physicians of the benefits herein specified and otherwise payable to me. I understand that I am financially responsible for the charges to all parties not covered by this assignment and/or third parties, etc.

OTHER CONSENTS

__ Yes __ No I understand that Solé Medical Spa Weight Management Center a division of Family PrimeCare, LLC is a teaching office and observation and participation are necessary for the teaching purposes. I give my permission for students pursuing a regular course of study to observe and participate in any care or procedure under proper supervision, deemed proper in the education process.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

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Last Name: _____ First Name: _____Middle Initial: _____

Social Security #: _____ Date of Birth: _____

Medical History:

Diabetes.....	Y	N	Hypertension....	Y	N	Heart Disease.....	Y	N
Stroke.....	Y	N	Cancer.....	Y	N	High Cholesterol.....	Y	N

Previous Hospitalizations / Surgeries / Serious Injuries	Dates	Medications
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: _____

Social History:

Marital Status:	Single Married	___	Separated	___	Divorced	___	Widowed ___
Use of Alcohol:	Never	___	Rarely	___	Moderate	___	Daily ___
Use of Tobacco:	Never	___	Quit	___	(Year _____)		Current Packs/day ___
Use of Drugs:	Never	___	Past Use	___	Current Use	___	(Type/Frequency)

Family History:

	Age	Diseases	If Deceased, Cause of Death
Father	___	_____	_____
Mother	___	_____	_____
Siblings	___	_____	_____
	___	_____	_____
Children	___	_____	_____
	___	_____	_____

Do you have any of the following?

Fatigue.....	Y	N	Loss of Appetite.....	Y	N	Dizziness.....	Y	N
Fever.....	Y	N	Nausea or Vomiting.....	Y	N	Seizures or Convulsions.....	Y	N
Eye Problems.....	Y	N	Change in Bowels.....	Y	N	Tingling Sensations.....	Y	N
Ear Problems.....	Y	N	Blood in Stool.....	Y	N	Tremors.....	Y	N
Sinus Problems.....	Y	N	Abdominal Pain.....	Y	N	Memory Loss.....	Y	N
Sore Throat.....	Y	N	Heartburn.....	Y	N	Confusion.....	Y	N
Voice Change.....	Y	N	Painful Urination.....	Y	N	Nervousness.....	Y	N
Chest Pains.....	Y	N	Frequent Urination.....	Y	N	Depression.....	Y	N
Palpitations.....	Y	N	Blood in Urine.....	Y	N	Insomnia.....	Y	N
Shortness of Breath.....	Y	N	Loss of Urine.....	Y	N	Excessive Thirst.....	Y	N
Swelling.....	Y	N	Joint Pains.....	Y	N	Heat or Cold Intolerance.....	Y	N
Coughing.....	Y	N	Joint Stiffness.....	Y	N	Dry Skin.....	Y	N
Wheezing.....	Y	N	Back Pain.....	Y	N	Easy Bruising.....	Y	N
Spitting up Blood.....	Y	N	Rash or Itching.....	Y	N	Bleeding Tendency.....	Y	N
Weight Loss.....	Y	N	Headaches.....	Y	N	Cold Extremities.....	Y	N

Women:

Painful Period.....	Y	N	Irregular Periods.....	Y	N	Vaginal Discharge.....	Y	N
Breast Pain.....	Y	N	Breast Lump.....	Y	N	Breast Discharge.....	Y	N

Last Menstrual Period _____ Last Pap Smear _____ # Pregnancies ____ # Miscarriages ___

Men:

Testicular Pain..... Y N Straining to Urinate..... Y N Impotence..... Y N

_____	_____	_____
Signature	Reviewed By	Date

SOLÉ MEDICAL SPA WEIGHT MANAGEMENT CENTER

CLIENT PROFILE QUESTIONNAIRE

DATE: _____ HOME PHONE: _____

NAME: _____ WORK PHONE: _____

ADDRESS: _____ CELL PHONE: _____

CITY/STATE/ZIP: _____ EMAIL: _____

PHARMACY: _____
SS#:_____

IN CASE OF EMERGENCY,
CALL:_____

GENERAL HEALTH & NUTRITION QUESTIONS

Personal Profile Information:

Gender: ___ Male ___ Female Birth date: _____

Weekly Exercise Information:

Explain in detail what type of resistance exercises, cardiovascular or sports activities you perform on average during a 7-day period.

Exercise/Activity Days/Week Duration

_____ _____ _____

_____ _____ _____

_____ _____
_____

Lifestyle/Professional Activity:

How would you rate the activity level of your profession, or what you do during the day (non-exercise related)?

___ Sedentary ___ Moderately Active ___ Active ___ Very Active

What are your goals?

___ Weight Loss ___ Maintain/Improve Eating Habits ___ Gain Weight

What is your goal weight? _____

Protein Requirements:

Which best describes you?

___ Sedentary Adult ___ Exercising Adult ___ Competitive Athlete
___ Growing Teenage Athlete ___ Adult Building Muscle ___ Athlete Restricting Calories

Body Type:

Which of the following statements best describes you?

___ I can eat practically anything I want and I do not gain weight. I find it very hard to gain weight.

___ I can lose or gain weight by adjusting my activity level and eating habits.

___ I find it difficult to lose weight. I can gain weight easily and have to watch what I eat.

Health & Medical Conditions:

Check any that apply or describe any other(s).

___ Heart Disease___ Anemia ___ Hypoglycemia ___ Liver Disease ___ Kidney Disease

___ Diabetes ___ Pancreatic Disease ___ Lactation ___ Hypertension

Other
_____
_____

Please list below everything you eat in one 24 hour period. Be sure to include snacks and beverages, including water. Also, show approximate amounts.

Time: ____ Food/Beverage:
_____
Time: ____ Food/Beverage:
_____
Time: ____ Food/Beverage:
_____
Time: ____ Food/Beverage:
_____
Time: ____ Food/Beverage:
_____
Time: ____ Food/Beverage:
_____
Time: ____ Food/Beverage:
_____
Time: ____ Food/Beverage:
_____
Time: ____ Food/Beverage:
_____

Make a list of your favorite foods:

_____
_____

_____
_____

_____

_____

Make a list of foods that you dislike:

_____

_____

_____

_____

_____

_____

Are you allergic to any types or kinds of foods?
_____
Have you ever been placed on any type of nutritional program in the past? ___
Yes___ No
If yes, by whom and what did it consist of? Please explain below:
_____
_____
_____
_____

What were your results?
_____

Have you ever had your body fat tested? ___ Yes ___ No
If yes, how was it tested and when?
_____

I, _____ AGREE TO ALLOW SOLÉ MEDICAL SPA WEIGHT MANAGEMENT CONSULTANT, TO DESIGN A WEIGHT MANAGEMENT PROGRAM FOR ME TO ENHANCE MY HEALTH & FITNESS GOALS. I WILL FOLLOW THAT PROGRAM TO THE BEST OF MY ABILITY AND I WILL NOT HOLD SOLÉ MEDICAL SPA OR ANY ONE RELATED PERSONS OR PARTIES PERSONALLY LIABLE FOR ANY PROBLEMS, ILLNESSES OR INJURIES THAT MIGHT OCCUR DUE TO A SUDDEN CHANGE IN MY EATING HABITS. THIS WEIGHT MANAGEMENT PROGRAM DOES NOT REPLACE THE EXPERT ADVICE OR MEDICAL TREATMENT OF MY OWN PRIVATE DOCTOR. I HAVE GIVEN SOLÉ MEDICAL SPA WEIGHT MANAGEMENT CENTER ALL NECESSARY INFORMATION ABOUT MYSELF TO PREVENT ANY POSSIBLE COMPLICATIONS AND I WILL UPDATE ANY OF THE INFORMATION GIVEN SHOULD THERE BE A CHANGE. I HAVE HAD ALL THE RISKS

(INCLUDING BUT NOT LIMITED TO THE USE OF DIET DRUGS SUCH AS PHENTERMINE) AND BENEFITS OF THE PROGRAM EXPLAINED AND THEY ARE FULLY UNDERSTOOD.

Signature: _____ Date: _____

SOLE MEDICAL SPA WEIGHT MANAGEMENT CENTER

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Please present your insurance card to the receptionist.

The metabolic testing cost is not included in your weight management program, but as a courtesy to our patients, we will bill your insurance for this test.

I understand that the metabolic rate test will be billed to my insurance.

Patient Signature:_____
Date:_____