CARRINGTON MEDICAL SPA
PATIENT INFORMATION FORM

Patient Name: (Last)________________________(First)________________________(MI)___

Name you prefer to be called: ____

Patient Address: ____

City: ____________________________________ State: ____________ Zip: ______________

Home Phone: ______________________________ Cellular: ______________________

Birthdate: _________________________________ Age: _______ Sex: M F

Email: ____

Employment Information

Patient Employer: __________________________ Occupation: _________________________

Employer Address: ____

City: ____________________________________ State: ____________ Zip: ______________

Work Phone: _____________________________________ Ext. __________________________

In Case of Emergency

Name: __________________ Relationship: _________________ Phone: ___________

Patient's Spouse: ____ Phone: ___________

Family Physician: ____ Phone: ___________

Referred by: ____

Financial Policy

Thank you for selecting CARRINGTON MEDICAL SPA 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, AMERICAN EXPRESS, DISCOVER, DEBIT CARD, AND CASH. NO CHECKS PLEASE.

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, and court costs.

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

____ ___________________________________

Patient's Signature Date

Carrington Medical Spa
Patient Insurance Information

Primary Insurance

Name of Insurance: ______________________________
Policy Holder's Name: ____________________________
Policy Holder's SS#: ______________________________
Employer: _____________________________________
Relationship to Policy Holder: _____________________
Policy #: _______________________________________
Group #: _______________ Phone #: ________________

Secondary Insurance

Name of Insurance: ______________________________
Policy Holder's Name: ____________________________
Policy Holder's SS#: ______________________________
Employer: ______________________________________
Relationship to Policy Holder: _____________________
Policy #: _______________________________________
Group #: ________________ Phone #: _______________

NEW PATIENT MEDICAL HISTORY FORM

Name: (First)_______________________________ (Last) _______________________________ (MI)____
Date of Birth: _____/_____/__________ Date of Visit: _____/_____/__________
Phone: (Home/Cell)________________________ (Work) ________________________ Gender: M / F
Referred By: _______________________________

How does your weight affect your life and health? ____
____
____

Weight History

When did you become overweight?

☐ Childhood ☐ Teens ☐ Adulthood ☐ Pregnancy ☐ Menopause

Did you ever gain more than 20 pounds in less than 3 months? Y / N If so, how long ago? _________
As best you can remember, how much did you weigh one year ago? _____
Five years ago? _____ 10 years ago? _____

Triggers for your weight gain (check all that apply):
☐ Stress ☐ Marriage ☐ Divorce ☐ Illness ☐ Medication abuse ☐ Travel ☐ Injury
☐ Nightshift work ☐ Insomnia ☐ Quitting (circle all that apply): Smoking / Alcohol / Drugs

Previous weight-loss programs (check all that apply):
☐ Weight Watchers ☐ Nutrisystem ☐ Jenny Craig ☐ LA Weight Loss ☐ Atkins
☐ South Beach ☐ Zone diet ☐ Medifast ☐ Dash diet ☐ Paleo diet
☐ HCG diet ☐ Mediterranean diet ☐ Ornish diet ☐ Other: ________________________

What was your maximum weight loss? ____
What are your greatest challenges with dieting? ____
____

Have you ever taken medication to lose weight? (check all that apply):
☐ Phentermine (Adipex) ☐ Meridia ☐ Xenecal/Alli ☐ Phen/Fen
☐ Phendimetrazine (Bontril) ☐ Topamax ☐ Saxenda ☐ Diethylpropion
☐ Bupropion (Wellbutrin) ☐ Belviq ☐ Qsymia ☐ Contrave
Other: ________________________
What worked? ____
What didn't work? ____
Why or why not? ____

Nutritional History

How often do you eat breakfast? _____ days per week at _____:_____ a.m.
Number of times you eat per day: _____
Do you get up at night to eat? Y / N If so, how often? _____ times
Daily servings of: Vegetables _____ Fruits _____ Meat _____ Dairy _____
Sweet beverages (check all that apply):
☐ Soda ☐ Juice ☐ Sweet tea ☐ Coffee/tea If so, how many times per day? _____

Number of times per week you eat fast food: Breakfast _____ Lunch _____ Dinner _____
Eating triggers (check all that apply):
☐ Stress ☐ Boredom ☐ Anger ☐ Seeking Reward ☐ Parties ☐ Eating Out
☐ Fast Food ☐ Other: _______________________

Food cravings:
☐ Sugar ☐ Chocolate ☐ Starches ☐ Salty ☐ High Fat ☐ Large Portions
Favorite foods: ____

Medical History
Exercise type: ____
Duration: _____ hours _____ minutes Number of times per week: _____
What prevents you from exercising? ____

How many hours do you sleep per night? _____ How times do you get up during the night? _____
Do you feel rested in the morning? _____

Past medical history (check all that apply):
☐ Heart attack ☐ Angina ☐ Gall bladder stones ☐ Sleep apnea
☐ High blood pressure ☐ Stroke ☐ Indigestion/reflux arthritis ☐ Thyroid
☐ High cholesterol ☐ Diabetes ☐ Celiac disease ☐ Anxiety
☐ High triglycerides ☐ Gout ☐ Pancreatitis ☐ Depression
☐ Infertility ☐ Polycystic Ovarian Syndrome
☐ Cancer (type/s): ____
Have you ever be diagnosed with an eating disorder? Y / N If yes, which one? __________________

Past surgical history (check all that apply):
☐ Gastric bypass ☐ Gastric banding ☐ Gastric sleeve ☐ Gall bladder ☐ Heart bypass
☐ Hysterectomy ☐ Other: ____

Medications (list all current medications and dosages):
____________________ ____________________ ____________________ ____________________
____________________ ____________________ ____________________ ____________________

Allergies:
(Medications)____
(Food)____

Social History
Smoking: ☐ Never ☐ Current smoker (_____ packs/day) ☐ Past smoker (quit _____ years ago)
Alcohol: ☐ Never ☐ Occasional ☐ Regularly (_____ drinks per day)
Prior treatment for alcoholism? Y / N
Drugs: ☐ Never ☐ Current ☐ Past ☐ Type of drugs: _______________________
Marijuana: ☐ Never ☐ Current user (_____ times/day)

Family History

Obesity (check all that apply): ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Diabetes (check all that apply): ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Other (check all that apply): ☐ High blood pressure ☐ Heart disease ☐ High cholesterol

☐ High triglycerides ☐ Stroke ☐ Thyroid problems ☐ Anxiety ☐ Depression

☐ Bipolar disorder ☐ Alcoholism ☐ Cancer (type/s): ____

Other: ________________________

Gynecologic History

Age periods started? _____ Age periods ended _____

Periods are: Regular / Irregular Heavy / Normal / Light

Number of pregnancies: _____ Number of children: _____

Age of first pregnancy: _____ Age of last pregnancy: _____

System Review

(Check all that apply)

☐ Recent weight loss more than 10 pounds

☐ Recent weight gain more than 10 pounds

☐ Acne ☐ Skin rash ☐ Cough

☐ Snoring ☐ Shortness of breath ☐ Chest pain

☐ Difficulty breathing when flat ☐ Fainting/Blacking out ☐ Palpitations

☐ Swelling ankles/extremities ☐ Abdominal pain ☐ Bloating

☐ Constipation ☐ Diarrhea ☐ Food intolerance

☐ Dysphagia/difficulty swallowing ☐ Indigestion ☐ Nausea/vomiting

☐ Increased appetite ☐ Decreased appetite ☐ Heartburn

☐ Gas and bloating ☐ Urinary frequency/urgency ☐ Slow urine flow

☐ Nighttime urination ☐ Loss of urine control ☐ Blood in stools

☐ Back pain (upper) ☐ Back pain (lower) ☐ Joint pain

☐ Muscle aches/pain ☐ Dizziness ☐ Headaches

☐ Seizures ☐ Weakness/low energy ☐ Anxiety

☐ Depression ☐ Insomnia ☐ Memory loss

☐ Inability to concentrate ☐ Mood changes ☐ Nervousness

☐ Loss of interest ☐ Cold intolerance ☐ Excessive sweating

☐ Hair changes ☐ Heat intolerance ☐ Blood clots

☐ Fatigue/tiredness

(Men only)

☐ Difficulty with erections ☐ Loss of interest in sex ☐ Low testosterone

(Women only)

☐ Absence of periods ☐ Hot flashes ☐ Change in bladder habits

☐ Abnormal/excessive menstruation ☐ Facial hair ☐ Loss of interest in sex

☐ Difficulty getting pregnant

Comments: ____

WEIGHT LOSS PROGRAM CONSENT FORM

I, ________________________________, authorize Dr. Liliya Slutsker and associated health care providers, to help me in my weight-reduction efforts. I understand that my program may consist of a balanced-deficit diet, a regular exercise program, instruction on behavior modification techniques, and may involve the use of anti-obesity medications. Other treatment options may include a very low-calorie diet or a protein-supplemented diet. I further understand that if medications are used, they have been used safely and successfully in private medical practices with experienced obesity medicine specialists as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with having excess weight or obesity. Risks of this program are usually temporary, reversible, and may include but are not limited to nervousness, sleeplessness, headaches, electrolyte abnormalities, dry mouth, gastrointestinal disturbances, weakness, fatigue, pancreatitis, psychological problems, gallstones, high blood pressure, rapid or slowing of the heartbeat and heart irregularities, and risk of weight regain. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints, including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight but will increase with additional weight gain over time.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees that the program will be successful. I also understand that obesity is a chronic, lifelong condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and it has been fully explained to me. My questions have been answered to my complete satisfaction.

________________________________ ____________________

Patient's Name (printed) Witness

________________________________ ____________________

Patient Signature Date

(or signature of person with authority to consent for patient)

RULES FOR USE OF ANTI-OBESITY CONTROL MEDICATIONS

NOTE: SIGNING THIS FORM DOES NOT GUARANTEE THAT YOUR PROVIDER(S) AT CARRINGTON MEDICAL SPA WILL FIND YOU TO BE AN APPROPRIATE CANDIDATE FOR ANTI-OBESITY MEDICATIONS, BUT ONLY THAT YOU HAVE READ, UNDERSTOOD, AND AGREE TO THE TERMS OF MEDICATION USAGE SHOULD YOU AND DR. Liliya Slutsker DECIDE UPON THEIR USAGE NOW OR IN THE FUTURE.

Many anti-obesity medications are considered “controlled medications.” By law, a controlled medication can only be prescribed from one facility at a time; therefore I agree that only Carrington Medical Spa will prescribe anti-obesity medications for me. I agree that it is my responsibility to inform my physician(s) at Carrington Medical Spa and any other providers from whom I receive treatment of all medications prescribed to me. **I understand that the use of anti-obesity medications is contra-indicated with certain medical histories, allergies, or other medication use**. I agree that I will be completely honest in disclosing this information and will notify my physician(s) at Carrington Medical Spa of any changes to my medical history or medication usage. I understand that failure to do so can be dangerous to my health.
I agree to take the medication only as prescribed and directed by Dr. Liliya Slutsker. I understand that taking medications in any way other than as directed and prescribed could affect my health and be dangerous. I also understand that medications are typically considered after a trial of failed weight loss with only nutritional/behavior modifications. If I am deemed a candidate for the medication program at Carrington Medical Spa, I am aware that the lowest effective dosage will be tried prior to increasing dosages.
I understand that medication prescriptions can be filled at a pharmacy of my choice. I agree to use only one pharmacy at a time to fill any scheduled anti-obesity prescriptions, and I give my permission for Carrington Medical Spa to notify area pharmacies of the terms of this agreement.
I will not share, sell, or trade my medication with anyone. I understand that doing so is illegal and will result in my discharge from the care of Carrington Medical Spa.

I understand that the use of some of the anti-obesity medications beyond 12 weeks is considered “off label” or not initially approved by the U.S. Food and Drug Administration (FDA). I understand that my physician(s) at Carrington Medical Spa are experienced specialist(s) in obesity medicine who will, at times, elect/choose, when indicated, to use the anti-obesity medication(s) for longer periods of time as deemed appropriate for my individual treatment.
I understand that I am to report any side effects or adverse reactions of my medications to the physician(s) at Carrington Medical Spa.
I understand that it is my responsibility to follow the instructions carefully and that the purpose of this treatment is to assist me in my desire to decrease my body weight for improvement of health and to maintain weight loss. I understand that the purpose of medications for weight loss is to be used as an adjunct to a program that includes nutrition and/or physical activity and/or behavior modification.

I agree that my physician(s) at Carrington Medical Spa may sometimes taper and/or stop my medication to evaluate its effect on my weight loss and/or hunger and health.

I understand that much of the success of the program will depend on my efforts and that there are **NO GUARANTEES** in medical treatment in the disease of obesity. I also understand that I will have to continue monitoring my weight after active weight loss.

Patient Signature: _______________________________________ Date: ____/____/________

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient name: (First) ___________________________ (Last) ___________________________
Date of birth: _____/_____/________
Address: __________________________ (City) ____________ (State) ______ (Zip) ________

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure.

Name: ____
Address: __________________________ (City) ____________ (State) ______ (Zip) ________

1. The type and amount of information to be used or disclosed is as follows:

▫ Complete health records	▫ Lab results/X-ray reports
▫ Physical exam	▫ Consultation reports
▫ Immunization record	▫ Other (please specify): ______________

2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. *This information may be disclosed to and used by LILIYA SLUTSKER, M.D., CARRINGTON MEDICAL SPA for the purpose of*

   ____

3. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ______________________________________

4. If I fail to specify an expiration date, event, or condition, this authorization will expire in 60 days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact LILIYA SLUTSKER, M.D.

______________________________________   ____________________
Patient's Name (printed)   Witness

______________________________________   ____________________
Patient Signature   Date
(or signature of person with authority to consent for patient)

Why I Want to Lose Weight…

Before you begin your weight-loss journey, it is important to spend time reflecting on why YOU want to lose weight. Make sure that that these are personal motivators and are not intended to please others.

Reviewing this list frequently will help keep you on track and focused on your personal commitment to take control of your health!

1.____

2.____

3.____

4.____

5.____

Describe the physical benefits you hope to get by losing weight:

____

____

Describe the functional benefits you hope to get by losing weight:

____

____

Describe the medical benefits you hope to get by losing weight:

____

____

Describe the psychological benefits you hope to get by losing weight:

____

____

How I Plan to Lose Weight…

Goal setting is the “how” of weight loss. Motivators are the “why.” When setting goals, utilize the SMART technique:

SMART	Technique	Example
Specific	Who, what, where, when, how…	“I want to lose 10 pounds in two months.”
Measureable	How will you track?	10 pounds in 8 weeks = 1.25 pounds/week
Attainable	Resources you have available, previous experience	“I have been able to do this before, and now I have new tools from my doctor!”
Relevant	Why this goal is important	Review your motivators above
Timely	Set benchmarks and deadlines	“Focusing for two month intervals works for me.”