I CARE WEIGHT LOSS CLINIC

YOUR FIRST APPOINTMENT

We value your time and want to help make your first appointment more efficient. Enclosed are a New Patient Information Form, a Medical History, and a Weight History. Please complete these forms and bring them with you to your first appointment.

Please read and follow these instructions:

1. Bring the completed forms to your first visit.
2. Please be on time. This allows us to make the best use of your time and is considerate of other patients. Being more than 15 minutes late will result in rescheduling your appointment. Please give at least 24 hours' notice for change or cancellation of your appointment.
3. We do not accept insurance. Payment is due at the time of service. We accept cash, and all major credit cards. The charge for your first visit will be $199.
4. We require that you have an EKG which will be done on your first visit. We ask that you do not wear lotion, body oil, Vaseline, or any other products that could make your skin feel oily. We need your skin clean and free of products the day of your first visit.
5. We will be doing a body composition analysis on your initial visit. This will give us your weight and BMI (Body Mass Index). Please wear shoes that are easy to take off.
6. We require blood work on all new patients. On your first visit, you will receive a prescription for these tests. Please get this blood work completed by your second visit. You will be responsible for any charges not covered by your particular insurance. To ensure the most accurate results, please fast for 12 hours prior to your blood draw. You should have nothing to eat during that time. Drink plenty of water and take your medications during your fasting hours. It takes 2 to 3 days for the results of your tests to be faxed to us, so please have your blood work done as soon as possible so Dr. Junaid A Syed can review the results with you at your second visit with us.
7. On your first and second visits to I Care Clinic, we request that you make arrangements for child care. This is an important time for you and Dr. Junaid A Syed to review your history, develop your own personalized plan for weight loss, and to discuss your test results.

We look forward to meeting you. If you have questions, please call 866-422-7367

Patient Information Form

Name: (Last) _____ (First) _____ (MI) _____

Name you prefer to be called: _____

Address: _____

City: _____ State: _____ Zip _____

Home phone: _____ Cell phone: _____

Birth date: _____ Age: _____ Sex: M F Marital Status: _____

Social Security #: _____ Drivers License #: _____

Country of Birth: _____ Country of Parents' Birth: _____

Education: Elementary High School/Technical School 2-yr College 4-yr College Graduate School

(Circle the highest level achieved)

Employment Information:

Employer: _____ Occupation: _____

Employer address: _____

City: _____ State: _____ Zip _____

Work phone No: _____ Ext. _____

In Case of Emergency:

Name: _____ Relationship: _____ Phone: _____

Patient's Spouse: _____Phone: _____

Family Physician: _____Phone: _____

How did you hear about us?

Referred by: _____

Newspaper: _____ Physician: _____

Other: _____

Financial Policy:

I will be paying today by ☐ Cash ☐ Credit Card

I agree that I have come to I Care Weight Loss Clinic to assist me in losing weight. I understand that by joining the weight management program I am agreeing to regular weekly visits, following the instructions I am given and that I will be responsible for full payment each week. For your convenience, we accept cash, and all major credit cards. 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 am looking forward to being thinner and healthier and commit to my share of the work ahead.

I have read and understand and agree to the Financial Policy.

_____ _____

Patient's Signature Date

I CARE WEIGHT LOSS CLINIC

MEDICAL HISTORY

NAME: _____

Do you have any of the following condition or have you had them in the past?

	NOW	PAST
Loss of Hearing		
Ringing In Ears		
Ear Infections		
Bad Vision		
Glaucoma		
Nose Bleeds		
Sinus Trouble		
Sore Throat		
Allergies		
Hoarseness		
Pneumonia		
Bronchitis		
Asthma		
Shortness of Breath		
Tuberculosis		
Heart Murmur		
Palpitations		
Irregular Pulse		
Swollen Ankles		
Chest Pain		
Loss of Appetite		
Indigestion		
Stomach Ulcers		
Diarrhea		
Constipation		
Bloody/Tarry Stools		
Hemorrhoids		
Hernia		
Gall Bladder		

	NOW	PAST
Sudden Weight Loss		
Liver Disease		
Back Pain		
Joint Pain		
Broken Bones		
Dizzy Spells		
Fainting Spells		
Memory Loss		
Insomnia		
Nervousness		
Depression		
Phobias		
Manic Depression		
Anxiety		
Schizophrenia		
Bulimia		
Anorexia		
Other Eating Disorders		
Frequent Urination		
Kidney Disease		
Kidney Stones		
Prostate Disease		
Headaches		
Migraines		
Fatigue		
Anemia		
Immune Disorders		
Alcohol Abuse		
Drug Abuse		

	NOW	PAST
Heart Disease		
Thyroid Disease		
Cancer		
Diabetes		
Stroke		
Osteoporosis		
GERD		
Rashes		
Chicken Pox		
Mumps/Measles		
Polio		
Nausea		
Vomiting		
Stomach Ulcers		
Heartburn/Reflux		
High Blood Pressure		
High Cholesterol		
Hepatitis		
HIV/AIDS		
MRSA		
Seizure/Epilepsy		
Leg Cramps		
Gout		
Malaria		
Thyroid Fever		
Cholera		
Hypoglycemia		
Arthritis		

FAMILY HISTORY: if a blood relative has suffered the following, please indicate the relationship

Heart Attack	
Cancer	
Hypertension	
Stroke	
Epilepsy/Seizures	
Arthritis	
Diabetes	
Obesity	
Glaucoma	
Other:	

Have you ever been hospitalized or had surgery? If YES, when and why?

YEAR	ILLNESS or SURGERY

Please list all known chronic conditions or medical illnesses:

ALLERGIES: Please list any medications you are allergic to.

NOTE: Patients allergic to SULFA will receive the chromic chloride injection in place of the MIC/B-COMPLEX.

MEDICATIONS: Please list any medications you are currently taking regularly and as needed; include over-the-counter medications.

MEDICATION	DOSAGE	HOW OFTEN	REASON

	YES	NO
Are you pregnant?		
Could you be pregnant?		
Are you breast feeding?		

In the past year, have there been any changes in your family? Check all that apply.

- ☐ Marriage
- ☐ Separation
- ☐ Divorce
- ☐ Loss of job
- ☐ Birth
- ☐ Death
- ☐ Other Serious Illness

Do you take: Check all that apply?

- ☐ Vitamins
- ☐ Laxatives Stomach
- ☐ Hormones Birth Supplements
- ☐ Pain Medication Nerve
- ☐ Medication Cold
- ☐ Control Pills
- ☐ Condition
- ☐ Medication
- ☐ Herbal

Please rate the intensity of any of these symptoms you have had in the past.

0 = NO PROBLEM 1 = MINOR PROBLEM 2 = BIG PROBLEM

- ☐ Hunger
- ☐ Mood Swings
- ☐ Dizziness
- ☐ Headache
- ☐ "Wired" Blurred
- ☐ Skin Rash Excess
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hot Flashes
- ☐ Anxiety
- ☐ Dry Mouth
- ☐ Vision Difficulty
- ☐ Urination Excess
- ☐ Palpitations
- ☐ Rapid Heart Rate
- ☐ Insomnia
- ☐ Irritability
- ☐ Shortness of breath
- ☐ urinating
- ☐ thirst Feeling
- ☐ Craving