# Florida Pain & Wellness Centers

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## MEDICAL WEIGHT LOSS INTAKE FORM

ALL INFORMATION IS CONFIDENTIAL

Name: _____ Date of Birth: ___/_____/_____

Address: _____

City: _____ State/Province: _____ Zip/Postal code: _____

Phone #: _____ Email: _____

☐Male: ☐ Female Emergency Contact: _____ #: _____

How did you hear about us? _____

What are your main weight issues and goals? _____

_____

Are you currently on any weight loss programs or special diet? Yes No If Yes, please explain: _____

_____

Do you smoke? Yes No If Yes, how many per day: _____

Do you consume alcohol? Yes No If Yes, what is your weekly consumption? _____

Do you take any medication, birth control, vitamins, mineral or herbal supplements? Yes No

If Yes, please list all medications: _____

_____

Do you exercise regularly? Yes No If Yes, please specify: _____

_____

Do you have any type of injury or have you had any type of operation in the last 12 months? Yes No

If Yes, please specify: _____

Do you have any Allergies Yes No If Yes, please list all allergies and/or reactions to drugs, food, latex, etc.:

_____

_____

FEMALE PATIENTS:

Are you currently: Pregnant Trying to get Pregnant Breast Feeding Post Menopausal

Have you had a Hysterectomy? Yes No If Yes, please lit date and explain reason: _____

_____

Number of Pregnancies: _____ Live Births: _____ Date of Last Menstrual Cycle: _____

MALE PATIENTS:

Have you had a Vasectomy? Yes No If Yes, please list date: _____

Are you currently trying to Conceive? Yes No _____

Please list all Surgeries and other Hospitalizations:

Reason: _____ Year: _____ Hospital: _____

Reason: _____ Year: _____ Hospital: _____

# WEIGHT LOSS INJECTIONS INTAKE FORM

Do you currently have or have you had any of the following Health Conditions (Check all that apply):

| | | | | |
|---|---|---|---|---|
| Alcohol Abuse | Anemia | Arthritis | Asthma | Bleeding Disorder |
| Bloody Stool | Bronchitis | Cancer | Chest Pain | Constipation |
| Convulsions | Depression | Diabetes | Diarrhea | Dizzy Spells |
| Drug Abuse | Eating Disorder | Epilepsy | Fainting Spells | Fatigue |
| Food Allergies | Frequent Urination | Glaucoma | Gout | Gallbladder Disorder |
| Headaches | Heart Disease | High Cholesterol | Hypertension | Insomnia |
| Irregular Pulse | Kidney Disease | Liver Disease | Lung Disease | Mental Illness |
| Migraines | Moodiness | Nervousness | Palpitations | Rashes |
| Shortness of Breath | Sleep Apnea | Stroke | Thyroid Disease | Ulcers |

Are you currently under the care of a Physician? Yes No If Yes, please list name of Dr. and Contact Info:

_____

Have you ever had weight loss surgery? Yes No If Yes, date of procedure: _____

If yes to above, Highest Pre-Surgery Weight: _____ Lowest Post Surgery Weight: _____

What do you feel are the main contributors to having excess weight? (Check all that apply):

| | | | | |
|---|---|---|---|---|
| Child Birth | Family History | Alcohol Intake | Busy Lifestyle | Emotional Eater |
| Sleep Issues | Hormone Changes | Medical Condition | Sedentary Lifestyle | Menopause |
| Stress | Excessive Snacking | Late Night Eater | Other: _____ | |

What foods do you crave most often and how often do you eat these foods? _____

_____

What methods have you used in the past for weight loss?

Exercise Diet Modifications Prescription Medications Weight Loss Pills Therapy Injections

Please list details of items marked above: _____

_____

Do you experience any potential weight loss obstacles below?

Skipping Meals Binge Eating Stress Eating Psychological Factors Unsupportive Partner None

Please specify if you marked any of the above items: _____

_____

How long has your weight been an issue? _____

What is your ideal weight? _____What is your heaviest weight? _____

Are you currently at your heaviest weight? Yes No If Yes, for how long? _____

*I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the practitioner or other health professional of my current medical health conditions and to update this history. A current medical history is essential for the practitioner to execute appropriate treatment procedures, I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.*

Patient Name: _____

Patient Signature: _____Date: _____

# WEIGHT LOSS INJECTIONS INTAKE FORM

Patient Name: _____Date: _____

The purpose of this informed consent form is to provide written information regarding the risks, benefits, and alternatives of Semaglutide and Tirzepatide+ injections. This material serves as a supplement to the discussion you have with your service provider. It is important that you fully understand this information, so please read this document thoroughly and put your initials in the appropriate boxes. If you have any questions regarding the procedure, ask your service provider before signing the consent form.

**THE TREATMENT**

Semaglutide and Tirzepatide+ are weight loss drug's that have recently had extensive clinical studies to prove its safety and efficacy. These are injectable medications that increase your satiety and reduce food intake. It works by mimicking the effects of insulin in your body which helps slow down the emptying of your stomach and signaling to your brain that your stomach is full, as a result you feel full for longer periods of time and eat less. This is not a quick fix though; you still must make smart food choices and get your body moving every day. Semaglutide and Tirzepatide+ are once-a-week injections that can easily fit in your busy schedule. The benefits help reduce hunger pangs and help you lose weight faster when you combine the injections with a low-calorie diet. It is best to take medication at night. **Initials: _____**

**RISKS AND COMPLICATIONS**

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Semaglutide and Tirzepatide+ may cause serious side effects, including: Inflammation of your pancreas (pancreatitis). Stop using the injections and call your service provider right away if you have severe pain in your stomach area (abdomen) that will not go away, with or without vomiting. You may feel the pain from your abdomen to your back. Semaglutide and Tirzepatide+ may cause gallbladder problems, including gallstones. Call your service provider if you have symptoms, such as pain in your upper stomach (abdomen), fever, yellowing of the skin or eyes (jaundice), or clay-colored stools. Increased risk of low blood sugar (hypoglycemia) in patients with type 2 diabetes, especially those who also take medicines for type 2 diabetes such as sulfonylureas or insulin. This can be both a serious and common side effect. Talk to your service provider about how to recognize and treat low blood sugar and check your blood sugar before you start and while you take Semaglutide or Tirzepatide+. Signs and symptoms of low blood sugar may include dizziness or light-headedness, blurred vision, anxiety, irritability, or mood changes, sweating, slurred speech, hunger, confusion or drowsiness, shakiness, weakness, headache, fast heartbeat, or feeling jittery. In people who have kidney problems, diarrhea, nausea, and vomiting may cause a loss of fluids (dehydration) which may cause kidney problems to get worse. It is important for you to drink fluids to help reduce your chance of dehydration. Stop using Semaglutide or Tirzepatide+ and get medical help right away, if you have any symptoms of a serious allergic reaction, including swelling of your face, lips, tongue, or throat; problems breathing or swallowing; severe rash or itching; fainting or feeling dizzy; or very rapid heartbeat. Tell your service provider if you have changes in vision during treatment.

Semaglutide and Tirzepatide+ can increase your heart rate while you are at rest. Tell your service provider if you feel your heart racing or pounding in your chest and it lasts for several minutes. You should pay attention to any mental changes, especially sudden changes in your mood, behaviors, thoughts, or feelings. Call your service provider right away if you have any mental changes that are new, worse or worry you. **Initials: _____**

The most common side effects of Semaglutide and Tirzepatide+ may include: nausea, diarrhea, vomiting, constipation, stomach (abdomen) pain, headache, tiredness (fatigue), upset stomach, dizziness, feeling bloated, belching, gas, stomach flu and heartburn. **Initials: _____**

# WEIGHT LOSS INJECTIONS INTAKE FORM

**PHOTO USAGE**

I give permission to take before and after photographs of my treatment to be used to monitor my treatment, training purposes, social media usage, and advertising. **Initials: _____**

**RIGHT TO DISCONTINUE TREATMENT**

I understand the I have the right to discontinue treatment at any time. **Initials: _____**

**RESULTS**

Typically, it takes about 2 weeks for Semaglutide and Tirzepatide+ to start working in the body. Some people begin to see results within the first eight weeks, but most begin to see results within 12 weeks. **Initials: _____**

I understand this is an elective procedure and I hereby voluntarily consent to treatment with Semaglutide or Tirzepatide+ injections for weight loss. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the Service provider who is treating me and I will direct all treatment questions or concerns to the treating physician. I have read the above and understand it. My questions have been answered satisfactorily. **Initials: _____**

I accept the risks and complications of the treatment and I understand that no guarantees are implied as to the outcome of the treatment. I also certify that if I have any changes in my medical history, I will notify the Service Provider who treated me immediately. I also state that I read and write in English. **Initials: _____**

Patient Name (Print): _____

Patient Signature: _____ Date: _____

I am the treating physician. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after treatment.

Physician Name (Print): _____

Physician Signature: _____ Date: _____