

HCG WEIGHT LOSS INTAKE FORM
 Dr. Nicole Schertell (ND, CCFP)
 Whole Life Health Care
 100 Shattuck Way
 Newington, NH 03801

Date: ___/___/___

Patient Name: _____ **Sex:** ___F___M

Date of Birth: ___/___/___

Home Address: _____ **City** _____ **State** ___ **Zip** _____

Home Phone: (____) _____ - _____ **Cell Phone:** (____) _____ - _____

Work Phone: (____) _____ - _____

Email: _____

Would you like to receive HCG Newsletters with helpful tips while you are on the program? Yes/No

List all medication and food ALLERGIES:

Please list any medical conditions (diagnosis) you are currently being treated for or that your doctor is considering treating you for:

List all medications with dosages (if possible) & why you are taking it:

List any supplements you are currently taking or should be taking according to your practitioner:

Do you smoke? (circle) Never Not in past 5 years Not in past 20 years Yes-Currently
If so, how many packs per week? _____

Do you drink alcohol? If yes, how many glasses per week? _____

When was your last physical examination by your primary care? _____

Have you had recent bloodwork done this year? If so, please list any tests you recall and mention if anything came back abnormal. (We would like to obtain copies of your most recent blood-work for our records.)

Have you had a colonoscopy within the past 5 years? Yes / No

Women Only:

Have you had a mammogram or breast thermography within the past year? Yes / No

Have you had a bone scan within the past 5 years? Yes / No

Do you suffer from menopausal symptoms? Yes / No

Do you suffer from PMS? Yes / No

Approximately when was your last menstrual cycle? _____

How many children have you given birth to? _____

Men Only:

Have you had a prostate exam? Yes / No

Do you have any urinary frequency/urgency or difficulty initiating urination? Yes / No

Weight History:

What is your height? _____ feet _____ inches

Most you have weighed _____

Least you have weighed as an adult? _____

What you weigh now _____

Over the past year have you (Circle One):

Gained Weight Lost Weight Maintained Weight

What is your Goal Weight _____

Are you currently attempting to get pregnant? Yes / No

Pregnant? Yes / No

Breastfeeding? Yes / No

Family History (circle all that apply):

Cancer

Diabetes

Heart Disease/Heart Attack

High Blood Pressure

Kidney Disease

Liver Disease

Obesity

Stroke

Gout

Depression

Other family history: _____

Please list all Past Surgeries you have had and approximate month/year of the surgeries:

_____	_____
_____	_____
_____	_____
_____	_____

Have you ever been hospitalized? If so, what was it for and when did it happen?

_____	_____
_____	_____

Do you have any significant health history or past illnesses? If so, please list along with the approximate dates:

_____	_____
_____	_____

Is there a particular event you are preparing for? Yes / No

If so what is the event and when is it? _____

What diets have you followed in the past?

_____	_____
_____	_____

Do you drink sodas of any kind? Yes / No If so: Occasionally or Daily

Do you eat breakfast? Yes / No

Do you skip meals? Yes / No

In your typical day, when are you the most hungry? _____

Do you eat out/purchase your meals more than 3 times a week? Yes / No

If so how many days a week? _____

What are your favorite foods or what foods do you crave?

_____	_____
_____	_____
_____	_____

Do suffer from any digestive issues after eating any particular foods?

_____	_____
_____	_____
_____	_____

Why do you feel you have had difficulties keeping the weight off?

Do you believe your friends or family members will be supportive of your weight loss?

What do you think will be the hardest part about doing this program?

Do you foresee any challenges arising while you are on this program? (ie. Social events, holidays, lack of family support, work environment, etc)

We offer group and individual classes that can offer additional support to patients during their transition from the HCG program into a more normal balanced diet. This program is particularly useful in teaching individuals how to reintroduce carbohydrates/starches in a way that promotes optimal fat burning (low glycemic eating techniques). This lifestyle program is helpful when patients are concerned about how to "keep the weight off" after they've lost it.

Would you like more information on the "Maintenance Lifestyle Program" upon completion of HCG weight loss? Yes / No

In addition to HCG Weight Loss, we offer a variety of other services through our family Naturopathic practice. Please check off any services that you would like to learn more about:

Bio-Identical Hormone Therapy (for peri/menopause or andropause)

NutriEval blood testing (will assess your body's level of vitamins, minerals, amino-acids, antioxidants, inflammation, and other markers-- which help to identify deficiencies and customized supplemental recommendations for optimal health.)

Natural treatments to improve sleep

Natural treatment to improve memory and focus

Food Sensitivity/Allergy Testing

Please check off any symptoms/conditions that you currently experience OR that you are prone to having:

General-

- Weight loss or gain
 - Fatigue
 - Fever or chills
 - Weakness
 - Trouble sleeping
-

Skin-

- Rashes
 - Lumps
 - Itching
 - Dryness
 - Color changes
 - Hair and nail changes
-

Head-

- Headache
 - Head injury (explain) _____
-

Ears-

- Decreased hearing
 - Ringing in ears (tinnitus)
 - Earache
 - Drainage
-

Eyes-

- Vision
 - Wear glasses or contacts
 - Pain
 - Redness
 - Blurry or double vision
 - Flashing lights
 - Specks
 - Glaucoma
 - Cataracts
 - Last eye exam date: ____ / ____ / ____
-

Nose-

- Stuffiness
 - Discharge
 - Itching
 - Hay fever
 - Nosebleeds
 - Sinus pain
-

Throat-

- Teeth (explain) _____
 - Gums (explain) _____
 - Bleeding
 - Dentures
 - Sore tongue
 - Dry mouth
 - Sore throat
 - Hoarseness
 - Thrush
 - Non-healing sores
 - Last dental exam
-

Neck-

- Lumps
 - Swollen glands
 - Pain
 - Stiffness
-

Breasts-

- Lumps
 - Pain
 - Discharge
 - Check if you DO perform self-exams
 - Currently breast-feeding
-

Respiratory-

- Cough (Circle: dry, wet, productive)
 - Sputum (color and amount) _____
 - Coughing up blood (hemoptysis)
 - Shortness of breath (dyspnea)
 - Wheezing
 - Painful breathing
-

Cardiovascular-

- Chest pain or discomfort
 - Tightness
 - Palpitations
 - Shortness of breath with activity (dyspnea)
 - Difficulty breathing lying down (orthopnea)
 - Swelling (edema)
 - Sudden awakening from sleep with shortness of breath
-

Gastrointestinal-

- Swallowing difficulties
 - Heartburn
 - Change in appetite
 - Nausea
 - Change in bowel habits
 - Rectal bleeding
 - Constipation
 - Diarrhea
 - Yellow eyes or skin (jaundice)
-

Urinary-

- Frequency
 - Urgency
 - Burning or pain
 - Blood in urine (hematuria)
 - Incontinence
 - Change in urinary strength
-

Genital-**Male-**

- Pain with sex
- Hernia
- Penile discharge
- Sores
- Masses or pain
- Erectile dysfunction
- STD's (list) _____

Female-

- Pain with sex
 - Vaginal dryness
 - Hot flashes
 - Vaginal discharge
 - Itching or rash
 - STD's (list) _____
-

Vascular-

- Calf pain with walking
(Claudication)
 - Leg cramping
-

Musculoskeletal-

- Muscle or joint pain
 - Stiffness
 - Back pain
 - Redness of joints
 - Swelling of joints
 - Trauma (explain) _____
-

Neurologic-

- Dizziness
 - Fainting
 - Seizures
 - Weakness
 - Numbness
 - Tingling
 - Tremor
-

Hematologic-

- Ease of bruising
 - Ease of bleeding
-

Endocrine-

- Head or cold intolerance
 - Sweating
 - Frequent urination (polyuria)
 - Thirst (polydypsia)
 - Change in appetite (polyphagia)
-

Psychiatric-

- Nervousness
- Depression
- Memory loss
- Stress

IMAGE OF HEALTH
Dr. Nicole Schertell, ND, CCT
100 Shattuck Way, Newington, NH 03801

HIPPA CONSENT FORM

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature: _____ Date: _____
Patient, parent or legal guardian

If signed by patient representative, state relationship to patient: _____