



We would like to welcome you to our office. Our medically supervised program will provide you with the foundation to accomplish your weight loss goals quickly and safely.

Your program begins with a consultation with a member of our medical staff. During this time you will be instructed on our nutritional plan which is proven to lower blood insulin levels. This process increases the body's ability to burn fat and creates the foundation of maintaining your weight loss. A comprehensive blood panel, an EKG, and your weight and body fat analysis will be performed. You will also be provided with a basic exercise regimen, which is a very important component to a successful weight loss program.

Our physician will then evaluate your medical and weight history, and make the appropriate recommendations for your individualized program. You will be prescribed and dispensed a Food and Drug Administration (FDA) approved appetite suppressant, which has been proven to be safe and effective for many years. Our program also utilizes weekly supplementary injections that will enhance your desired weight loss outcome.

Our program requires weekly scheduled visits to assess your progress, dispense your medication and make any indicated changes. We take great pride in our program, and thank you for your interest.

Kind Regards,

Dr. Jakob and Staff

FIRST NAME	LAST NAME
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DOB	AGE	GENDER <b>M</b> <b>F</b>	SOCIAL SECURITY NUMBER
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STREET ADDRESS	CITY	STATE	ZIP
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EMPLOYER	OCCUPATION
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HOME PHONE	WORK PHONE
Can we contact you at this number?   Yes   No	Can we contact you at this number?   Yes   No

CELL PHONE	EMAIL ADDRESS
Can we contact you at this number?   Yes   No	Can we contact you via Email?   Yes   No

EMERGENCY CONTACT	PHONE NUMBER
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Supporting you in your journey of weight loss and maintenance is important to us. Therefore, we may wish to send you information, samples, or special offers we feel may be of interest. Your information will be kept strictly confidential and not provided to third parties.		
Send via postal mail	Send via text	Send via Email

How did you hear about us?
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## Weight History

Name		Date
Height	Weight	Goal Weight

How long have you been trying to lose?
What has been your heaviest weight?
When were you that weight? (record your age)
When did you first become overweight?
What do you think is the cause of your weight problem?
Have you ever stayed the same weight for ten (10) years or more?
Are any members of your household overweight? If yes, please list relation and details.

What was your motivation for weight loss before seeking our program?		
Don't like the way I look	Clothes don't fit anymore	Feel more confident socially
More energy	Improve health	Look more attractive for partner
Better work opportunities	Feel better	Reduce medications
More mobility	Want to wear smaller sizes	Want to wear stylish clothing
Attend wedding/graduation	Upcoming vacation	Upcoming anniversary/birthday
Attend a reunion	Look better	Other (please describe below):
Perform better	Live longer	

Do you ever eat in secret?
Do you believe yourself to be fat when others say you are thin?
Do you feel driven to perform certain acts over and over like washing or cleaning?
Do you often straighten, arrange, or order common household objects to make them "just right?"

## Medical History

Family History (If blood relative has suffered the following, please indicate relationship.)				
Heart Attack		Arthritis		
Cancer		Diabetes		
Hypertension		Obesity		
Stroke		Glaucoma		
Epilepsy		Other		
Have you ever been hospitalized? If yes, when and why?				
Year	Illness or Operation			
Medications. Please list the medications you are currently taking.				
Medication	Dosage	How often	Reason	
Allergies. Please list any medications you are allergic to.				
Medical History. Circle all that apply.				
Loss of hearing	Ringing in ears	Ear infections	Bad vision	Glaucoma
Nose bleeds	Sinus trouble	Sore throat	Allergies	Hoarseness
Pneumonia	Bronchitis	Asthma	Short 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	Sudden weight loss
Liver disease	Back pain	Joint pain	Broken bones	Dizzy spells
Fainting spells	Memory loss	Insomnia	Nervousness	Depression
Phobias	Manic depressive	Anxiety	Schizophrenia	Bulimia
Anorexia	Eating disorder	Frequent urination	Kidney disease	Prostate disease
Headaches	Fatigue	Anemia	Immune disorders	Alcohol abuse
Drug abuse	Hypertension	Heart disease	Thyroid disease	Cancer
Diabetes	Stroke	Osteoporosis	GERD	Rashes
Chicken pox	Mumps/measles	Polio	Are you pregnant?	Other

In order to assist you in achieving your weight loss goal, please check the programs that you have previously participated in. Please list under comments if you were successful in obtaining your goal, and if not why the program did not meet your expectations.

Name of Program	Results	Why this program fell short of your expectations...
Weight Watchers		
Jenny Craig		
Slim Fast		
Atkins		
South Beach		
LA Weight Loss		
Nutri System		
Other		

Do you exercise? If so, how often?					
Never	Rarely	Once a week	2-3 times per week	4-5 times per week	Daily

What is your exercise routine? Circle all that apply.	
Walking	bicycling
Swimming	Yoga
Dancing	Sports (basketball, tennis, etc.)
Pilates	Strength training
Stairmaster	Elliptical
Aerobics	Treadmill
Jogging	Other (please describe below)

## **Appetite Suppressant and Weight Loss Consent**

I hereby authorize Dr. Jakob and associates to assist me in weight reduction. I understand that my program may consist of a balanced calorie deficient diet, regular exercise program, and lifestyle changes. I also understand that appetite suppressants, other medications, and injections may be used in my program for up to and possibly more than 12 consecutive weeks. The experience of Bariatric Physicians, as well as recent long-term studies of university-based investigators, has shown that appetite suppressants, supplements, and injections are effective for longer than 12 weeks.

Dr. Jakob and associates believe in the off label use of medications proven to be effective in medical studies to promote weight loss and in the use of nutritional supplements and injections. These injections, nutritional supplements and medications can help you lose weight faster and make you feel better while you are losing weight. These nutritional supplements, injections and medications can boost your energy, burn fat faster, and eliminate cravings. Dr. Jakob and associates follow the guidelines set forth by the American Society of Bariatric Physicians. There are those practicing Bariatric Medicine that do not hold to these beliefs regarding the effectiveness of nutritional supplements, injections, and medications. Many of these physicians believe that in order to lose weight you simply need to exercise and or eat fewer calories. Dr. Jakob and associates disagree with this simplistic thinking, and believes that the nutritional supplements and injections that are prescribed are effective and therapeutic. If you have any problems or questions, please inform one of our medical associates immediately.

I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting or an exchange-eating program without the use of the appetite suppressants would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

In order to continue to receive appetite suppressants, other medications, and injections depends on continued weight loss. The use of appetite suppressants, other medications, and injections involves potential risks. Reported side effects include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, medication allergy, high blood pressure, rapid heart beat, and heart irregularities. These and other risks could, on occasion, be serious.

I understand that there are risks associated with obesity. Among these risks are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints, hips, knees, and feet. I also understand that thirty to forty percent of overweight or obese patients may have or develop gallstones. A large percent of this group will develop significant gallbladder disease during their lifetime. I also understand that rapid weight loss programs may increase the incidence of symptomatic gallbladder disease.

I understand that if I develop side effects from the diet or the medication, I will discontinue the diet and/or the medication and notify a member of your medical staff immediately. I also understand that if the problem is severe, I will go to the nearest Emergency room or see my primary care physician as soon as possible.

There is no guarantee that the program will work for me. By consenting to treatment, I agree to pay in full for all visits and charges at the time of each visit. I understand that your services may not be reimbursed by insurance, and that you do not provide or fill out claim forms for insurance purposes unless prior arrangements are made. I understand that no refunds are give at any time for any reason. I also understand that the medications dispensed to me during my weekly visits are included for quality assurance and my convenience: however, I may request that a prescription to be written for the weekly dose of the medication.

By signing below I certify that I have read and fully understand this consent form. I should not sign this form if I have any questions or concerns that have not been answered to my complete satisfaction. My signature further confirms that I do not have a history of alcohol abuse, drug abuse, schizophrenia, manic-depressive illness, or history of any eating disorder since these conditions constitute a contraindication to the use of appetite suppressants. I agree not to take any other appetite suppressants, other medications, or injections other than those prescribed by Dr. Jakob or this office's physician, or listed on my medical history form. I agree to inform a member of your medical staff of any changes in my medications.

If a female, my signature confirms that I am not pregnant, do not plan to become pregnant, and I will take all necessary precautions to prevent pregnancy during the time I will be taking appetite suppressants. If I become pregnant, I will stop the medication immediately and notify your office.

I further understand that Cara Jakob, M.D. Total Family Healthcare and Wellness and all written materials describing your program or any of its parts, and all applicable trademarks, copyrights and other intellectual property in or to your program and related materials are and remain your absolute property. I acknowledge that I am purchasing a non-exclusive, non-transferable license to use your program and the related written materials for my own use, and that I have no right to duplicate or to sell, lend or otherwise transfer to any other person or to make any commercial use of our program or related written materials. I may not modify, publish, distribute, perform, participate in the transfer or sale, create derivative work of, or in any way exploit any of the content, in whole or in part.

My signature below indicates my consent of treatment.

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

# Receipt of Notice of Privacy Practices

Written Acknowledgement Form

I, \_\_\_\_\_, have received a copy of Cara Jakob, M.D. Total

Patient Name

Family Healthcare and Wellness Notice of Privacy Practices.

Patient \_\_\_\_\_

Date: \_\_\_\_\_

# Patient authorization for disclosure of protected health information

I, \_\_\_\_\_, D.O.B. \_\_\_\_\_,

SS# \_\_\_\_\_, authorize Cara Jakob, M.D. and or staff to release information to the following individual regarding my appointment and account history, and hereby authorize these individuals to reschedule, verify, or make appointments and cancellations, and tender payment on my behalf.

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Patient \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_