PERSONAL HISTORY

Today's Date: ____________________

PATIENT INFORMATION

Name (*First MI Last*): ________________________________ Preferred Name: ______________
Address: ____
City: ____ State: ________ Zip: __________
Mobile: ________________ Home: ________________ Work: ____________________
Email: ____

Marital Status: ______________ Date of Birth: ______________ Gender: M / F

Type of Work: ________________________________ Employer: ____________________

*Referred By (*Name*): ____________________________ Family / Friend / Co-Worker / Doctor / Other

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Current Weight: ____________________________ **Desired Weight:** ____________________

Desired Completion Date: ______________________

Weight loss can be complex. If you have failed in the past, it could be because you have some of the following issues.

- ☐ Fatigue
- ☐ Difficulty getting to sleep
- ☐ Difficulty staying asleep
- ☐ High amounts of stress
- ☐ Over-heating
- ☐ Cold hands and feet
- ☐ Low sex drive
- ☐ Menopause
- ☐ Fatigue after meals
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas after a meal
- ☐ Frequent urination
- ☐ Sugar cravings
- ☐ Irritable if meals are missed
- ☐ Depression
- ☐ Fibromyalgia
- ☐ Mental Fatigue
- ☐ Knee Pain
- ☐ Joint Pain
- ☐ Hip Pain
- ☐ Muscle Pain
- ☐ Back Pain
- ☐ Taking Pain Medication

Current Medications or Supplements: ____
____
____
Surgeries: ____
Hospitalizations or Health Issues: ____

If there there was something you could do about these conditions, *would you do it?* ☐ YES ☐ No

REVIEW OF SYSTEMS

General: (constitutional)
☐ Recent weight change
☐ Fever
☐ Fatigue
☐ None in this category

Musculoskeletal:
☐ Low Back Pain
☐ Mid Back Pain
☐ Neck Pain
☐ Arm Problems
☐ Leg Problems
☐ Painful Joints
☐ Stiff/Swollen/Joints
☐ Sore/Weak Muscles
☐ Muscle Cramps/Spasms
☐ Broken Bones
☐ None in this category

Ears, Nose and Throat:
☐ Bad Breath or bad taste
☐ Dental problems
☐ Bleeding gums/sores
☐ Swollen throat/voice change
☐ Ringing in the ears
☐ Swollen glands in neck
☐ Ear Ache/Ringing/Drainage
☐ Sinus/Allergy problems
☐ Nose Bleeds
☐ Hearing Loss
☐ None in this category

G**enitourinary:**
☐ Sexual Difficulty
☐ Kidney Stones
☐ Burning/Painful Urination
☐ Change in force of urination
☐ Frequent Urination
☐ Blood in Urine
☐ Incontinence or Bed Wetting
☐ None in this category

Cardiovascular:
☐ Heart Problems
☐ Chest Pains
☐ Rapid Heartbeat
☐ Blood Pressure Problems
☐ Swelling of Hands
☐ None in this category

Eyes/Vision:
☐ Wear contacts/glasses
☐ Blurred/Double vision
☐ Glaucoma
☐ Eye disease/injury
☐ None in this category

Gastrointestinal:
☐ Abdominal Pain
☐ Blood in Stool
☐ Change in Bowel Movements
☐ Painful Bowel Movements
☐ Nausea or Vomiting
☐ Constipation
☐ Frequent Diarrhea
☐ Loss of Appetite
☐ None in this category

Neurological:
☐ Numbness or tingling
☐ Loss of feeling
☐ Dizziness/Lightheaded
☐ Frequent/Recurring Headaches
☐ Convulsions/seizures
☐ Tremors
☐ Stroke
☐ None in this category

Mind/Stress:
☐ Nervousness
☐ Depression
☐ Sleep Problems
☐ Memory Loss/Confusion
☐ None in this category

Skin, Nails:
☐ Rash or Itching
☐ Change in Skin Color
☐ Non-healing issues
☐ Change in hair or nails
☐ Change in mole appearance

☐ None in this category
☐ Dry Skin
☐ Easily Bruise or Bleed
☐ Anemia
☐ None in this category

Respiratory:
☐ Difficulty breathing
☐ Persistent coughing
☐ Asthma or Wheezing
☐ Lung Problems
☐ Coughing blood
☐ None in this category

Endocrine, Hematologic, & Lymphatic:
☐ Thyroid Problems
☐ Diabetes
☐ Excessive Thirst/Urination
☐ Cold Extremities
☐ Heat or Cold Intolerance
☐ Swollen Glands
☐ Change in hat/glove size
☐ Glandular/hormone issues
☐ Phlebitis
☐ Immune Disorders
☐ Transfusion

Women Only:
☐ Painful or Irregular periods
Are you pregnant? ☐ No
☐ Yes, Due Date: ____________
☐ Previous Pregnancies _______
☐ Infertility
☐ Vaginal Discharge
☐ Breast Pain/Discharge
☐ None in this category

Patient Signature ____ Date _______________________________

Weight Loss Practice & Payment Policies

Patient Name: ____

D.O.B.:____

Date: ____

1. PAYMENT is expected as per the agreement on the Custom Weight Loss Plan. We will accept cash, check, or credit card. Your account must be in good standing to receive treatments. Any balance due must be paid prior to services and treatments being rendered. Late charges of 12% annually will be applied to all patient balances 90 days old or greater.

2. RETURNED CHECKS will incur a $30 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $30 service fee and collections action.

3. COLLECTION FEES I understand that in the event my account is placed in collection status, any additional fees incurred will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand the additional fees will be my personal responsibility to pay in full.

4. CANCELLATIONS OR MISSED APPOINTMENTS If you are unable to make your appointment, please call the office to reschedule as soon as possible. Missed appointments or cancellations made within 24-hours of your appointment will be subject to a $25 cancellation fee, due before your next treatment.

5. TARDINESS Please be on time for your appointments. Patients who have arrived late may be seen after patients who have arrived for their appointment on time. New patients that are more than 15 minutes late to their scheduled time will be rescheduled.

6. RELEASE OF PERSONAL INFORMATION I hereby authorize the and direct Dr. Neal Cobb, D.C / Cobb Wellness Clinic to release to governmental agencies, insurance carriers, or other healthcare facilities and associates who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

We are very concerned with protecting your personal and health information. By signing below, you have authorized this office to contact you for office related health matters. Messages may be left on an answering machine/voicemail, or with the person answering your phone. Your cell phone number may be used for text (SMS) messages with upcoming appointment reminders. Emails may be sent to you regarding your current health and wellness program, billing reminders or office updates and marketing. Mailings from the office will be sent to the address on file and may include billing statements and marketing materials.

The office will supply you with a copy of this office privacy policies and procedures upon your request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below, you gave acknowledged that you have been offered a copy of this document.

Patient Signature:____

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