

Permanent Weight Loss System Application

Thank you for applying to the Northland Medical and Wellness Center, LLC permanent weight loss system!

Please take a few minutes to complete the following forms.

Last Name: _____ First Name: _____ MI: _____ Age: _____ Please Circle: Male / Female

Address: _____ City, State, Zip: _____ Home Phone: _____

Cell Phone: _____ Email: _____ Employer: _____ Work Phone: _____

Date of Birth: ____/____/____ Social Security # _____

Family Physician: _____ Phone: _____

What are your health goals: 1) _____

2) _____

3) _____

On a scale of 0-10 (0-not committed and 10-whatever it takes) how dedicated are you to meeting your health goals? _____

How many glasses of water do you consume per day?: _____

On a scale of 0-10 (0-not an issue and 10-major issue) how would you rate your stress level on a daily basis?: _____

How often do you exercise? (please check) Daily Weekly Monthly

Please describe the activities: _____

Do you feel fatigued on a regular basis? Y / N

Does fatigue prevent you from doing things you want to do? Y / N

Does fatigue interfere with your work, family, or social life? Y / N

Please list the foods and amounts you eat in a typical day:

Breakfast	Lunch	Dinner	Snacks
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any prescription medications that you are taking or have taken in the past 6 months:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

Please list any over the counter medications that you are taking or have taken in the past 6 months:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

Please list any supplements that you are taking or have taken in the past 6 months:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

Medical History: Please check all that apply

- | | | |
|---|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Diverticular Disease | <input type="checkbox"/> Neurological Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Allergies (Hay fever) | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eyes, Ears, Nose Throat | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Environmental Sensitivities | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Gastroesophageal Reflux | <input type="checkbox"/> Seasonal Affective Disorder |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout Heart Disease | <input type="checkbox"/> Skin Problem |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Infection, Chronic | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Inflammatory Bowel Disease | <input type="checkbox"/> Urinary Tract Infections |
| <input type="checkbox"/> Cholesterol-Elevated | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Kidney or Bladder Disease | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Kidney Stones | |
| <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Liver or Gallbladder Disease | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Migraine Headaches | Other _____ |
| <input type="checkbox"/> Diabetes | | |

Operations:

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Prostate | <input type="checkbox"/> Cholecystectomy |
| <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> _____ |

Allergies (please list):

_____ _____ _____

Social History: Please circle all that apply.

Married: Yes No If yes, how long _____ Children: Yes No If yes, how _____

Tobacco: Yes No Please Circle: Cigarettes Cigars Chewing Tobacco If yes, how much/day _____ How many years _____

Alcohol: Yes No If yes, drinks/day or week _____ Coffee: Yes No If yes, cups/day _____

PMI/FH:

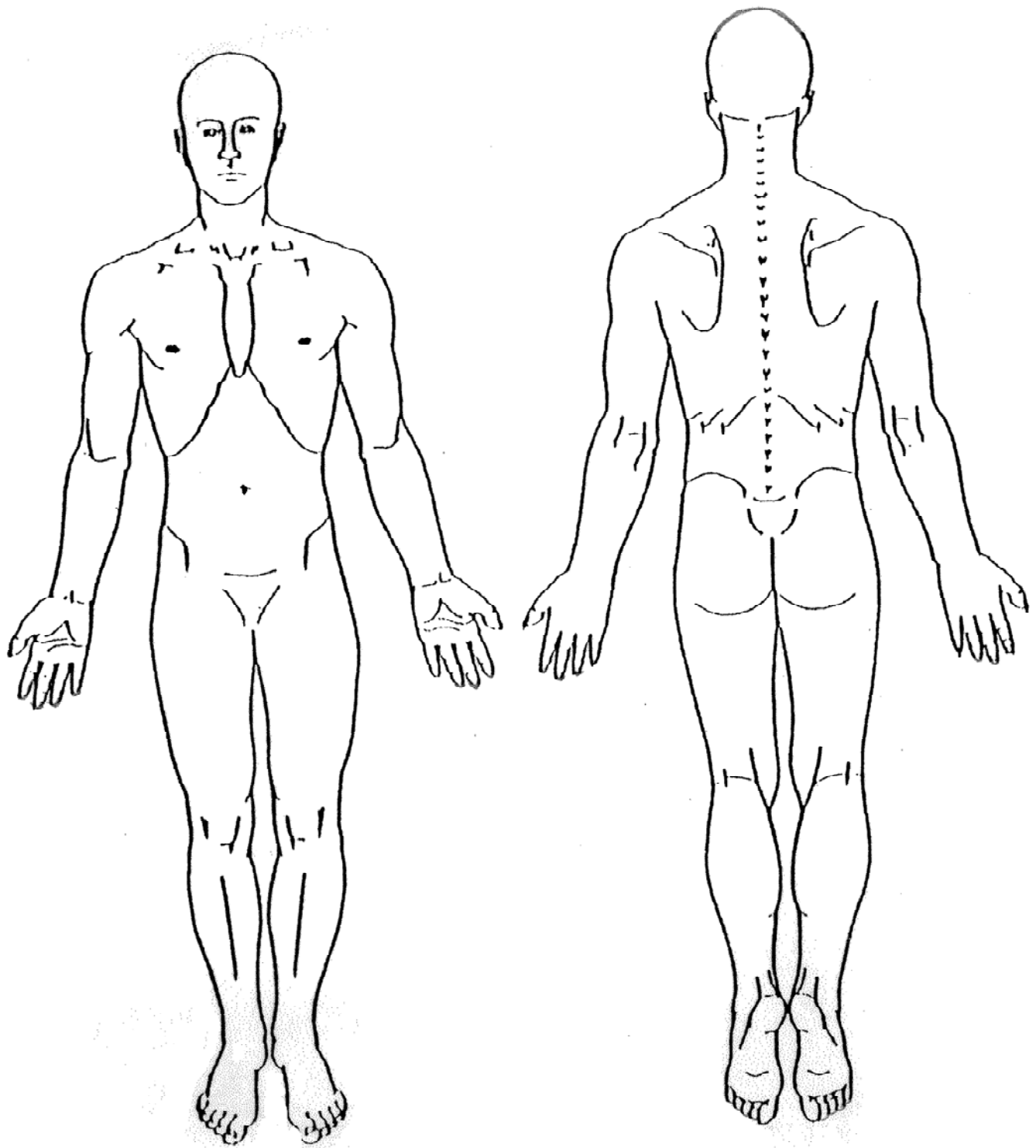
Have any of your family members had any of the problems listed in the chart? Please indicate by checking the appropriate box.

	Father	Mother	Grandparents	Siblings	Children
Alcoholism					
Anemia					
Arthritis					
Asthma					
Cancer					
Diabetes					
Emphysema					
Heart Disease					
High Blood Pressure					
Osteoporosis					
Mental Illness					
Thyroid Disorders					

Please check the boxes below that reflect any pain or other symptoms that you may be experiencing or experienced in the past 6 months:

	Pain	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling
Head							
Neck							
Upper Back							
Mid Back							
Lower Back							
Shoulder							
Arm							
Forearm							
Wrist							
Hand							
Ribs							
Buttock							
Hip Thigh							
Leg							
Knee							
Ankle							
Foot							

Please circle/mark your area(s) of the signs and symptoms listed



Patient Responsibilities

The Northland Medical & Wellness Center Weight Loss System is designed to provide you with the very best education, motivation, service and direction to help you reach your goals of health and well-being. Our team is committed to one goal: to see you succeed!

We are very proud of the people that we serve and we hold them to the highest standards. Our medical and fitness team will give no less than 100% to ensure that you achieve your goals. To be accepted into this program, we require that same 100% commitment from you. We will only accept you as a patient if we can guarantee you results. Therefore, while you are a patient of Northland Medical & Wellness Center we expect the following:

- Maximum Focus
- Maximum Effort
- Honesty
- Consistency
- Enjoyment of the Process

In addition, you will be required to attend at least 3 educational seminars. During this time we will provide you with nutritional information that will help you understand how to take care of your body. We believe that education is the key to your success! To get the most out of this program, we ask that you sign this contract stating that you:

- Are 100% committed to improving your health
- Are willing to give your maximum effort
- Will be honest with yourself so we may strive for excellence together.

Patient Signature: _____

Date: _____

NM&WC Rep. Signature: _____

Date: _____