

# RèvaSlim Weight Loss Centers - Registration Form

Office Use Only

Chart:
Date:
Entered By:

Mr.  Miss Last Name: First: Middle: Martial Status:  
 Mrs.  Ms.  Single  Married  
 Dr.

Gender: Birth Date: Age: Email Address:  
 M  F / /

Address:

City: State: Zip: Occupation:

Home Phone: Work Phone: Cell Phone:  
( ) ( ) ( )

How were you referred to RèvaSlim Weight Loss Centers?  
 Invitation mailer  Website  Referral Card  T.V.  Other: \_\_\_\_\_  
 Radio  Coupon  Patient / Friend  Walk-In \_\_\_\_\_  
 Newspaper  Magazine  Employee  Physician Referral \_\_\_\_\_

Service(s) requested for today: (check all that apply)  
 Weight Loss  RèvaLite Energy or B12  Dietary Supplements

## Emergency Contact

Local Friend / Relative Name: Relationship: Phone Number: Work Number:  
( ) ( ) ( ) ( )

## Nutritional Evaluation

Your Weight Loss Goal	Current Weight:	Current Height:	Goal Weight:
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In what time frame would you like to reach your goal?

What is the main reason for your decision to lose weight?

When and what are the reason(s) for your weight gain?

What would you say is the biggest obstacle(s) to your weight loss?

Previous diets tried and results for each:  
\_\_\_\_\_  
\_\_\_\_\_

## Medical History

Primary Physician: Physician's Phone Number:  
( ) ( )

Are you currently under the care of a physician?  Yes  No  
If yes, for what reason?

Current Medications: (Please list all precription, over the counter medications, vitamins, herbs, and/or dietary supplements.)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Medical History Continued)

Do you have any allergies to medication, food, or latex products?  Yes  No

If yes, please list:

**Phentermine is not recommended for clients with a history or current condition of any of the following:**

**Do you have a history of any of the following? (Check all that apply)**

- |  |   |
|--|---|
| <input type="checkbox"/> High Blood Pressure                         | <input type="checkbox"/> Pulmonary Hypertension           |
| <input type="checkbox"/> Diabetes (date of diagnosis ____/____/____) | <input type="checkbox"/> Hyperthyroidism / Hypothyroidism |
| <input type="checkbox"/> Heart Attack or Heart Condition             | <input type="checkbox"/> Constipation or diarrhea         |
| <input type="checkbox"/> Glaucoma                                    | <input type="checkbox"/> Sleep Apnea                      |
| <input type="checkbox"/> Frequent Headaches or Migraines             | <input type="checkbox"/> Swelling in feet                 |
| <input type="checkbox"/> Breast-feeding                              | <input type="checkbox"/> Pregnant or think you might be?  |

**Past Medical History (check all that apply)**

- Cardiovascular or heart disease (high blood pressure, heart attack, congestive heart failure, irregular heart rate and/or rhythm)
- Lung Disease (asthma, pneumonia, COPD, tuberculosis, pleurisy, pulmonary, hypertension)
- Kidney Disease (chronic urinary tract infection, kidney stones)
- Thyroid Imbalance (hypothyroidism, hyperthyroidism)
- Liver Disease (jaundice, hepatitis)
- Gastrointestinal Disorders (ulcers, reflux, gallbladder, disease)
- Bleeding Disorders (anaemia, clotting disorder, history of blood transfusion)
- Cancer
- Measles
- Mumps
- Osteoporosis
- Scarlet Fever
- Drug Abuse
- Alcohol Abuse
- Psychiatric Illness
- Eating Disorder
- Nervous Breakdown
- Rheumatic Fever
- Whooping Cough
- Tonsillitis
- Chicken Pox

**Family Medical History (check all that apply)**

**Has any blood relative ever had any of the following?**

Yes	No	If yes, please list who below
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	Overweight / Obese

**Surgeries & Hospitalizations History**

Date	Reason/Diagnosis

**Women Only**

- Are you currently breastfeeding?  Yes  No
- Are you or do you suspect you may be pregnant?  Yes  No
- Date of last menstrual period? \_\_\_\_/\_\_\_\_/\_\_\_\_

## Dietary History

How many times in a week do you eat out?

How often do you eat "fast food" in a week?

When eating out, what types of food do you eat?

Typical Breakfast          Time Eaten:	Typical Lunch          Time Eaten:	Typical Dinner          Time Eaten:
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Describe your daily caffeine intake:  High  Medium  Low  None

What type of caffeine do you drink?  Tea  Soda  Coffee  Other:

How many cups/cans do you drink per day?

What foods do you typically crave?

What foods do you avoid?

What are your worst food habits?

What are your snack habits?

Do you awaken hungry during the night?  Yes  No

## Activity Level

Which one most accurately describes you:

Inactive - no regular physical activity

Light Activity - occasional walking, jogging, cycling, swimming

Moderate Activity - regular participation in exercise more than 30 minutes at least 3 times per week

Have you ever used the services of a personal trainer?  Yes  No

If yes, When and why did you stop?

## Social History

Tobacco	Do you or have you ever smoked? <input type="checkbox"/> Yes <input type="checkbox"/> No
	How many packs per day?                      How many years?
	When did you stop smoking?
Alcohol	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what type do you drink? <input type="checkbox"/> Beer <input type="checkbox"/> Liquor <input type="checkbox"/> Wine
	How many drinks per day?                      Per Week?
Drugs	Do you use or have a history of use of illicit drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, how long?
	When did you stop using?

## Behavior Style (select one)

- |   |   |
|---|---|
| <input type="checkbox"/> You are always calm and easygoing    | <input type="checkbox"/> You are usually calm and easygoing   |
| <input type="checkbox"/> You are sometimes calm and easygoing | <input type="checkbox"/> You are never calm                   |
| <input type="checkbox"/> You are seldom calm                  | <input type="checkbox"/> You are hard-driving and never relax |

I have fully disclosed all of my medical history. I understand that it is my responsibility to inform and update the medical provider of any changes in my health status and medical history. I understand that omission of information may affect my plan of treatment.

I consent to allow Nurse Practitioners, PLLC and RêvaSlim to use the results of my weight loss treatment as part of their study to determine the effectiveness of their weight loss plans as long as my name is in no way associated with their use of information.

Client Signature:

Date / Time: