West Valley
Health & Wellness

Personal Information:					
☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Dr.	First Name:	Middle:	Last Name:		
Address:	City:	State:	Zip:		
Gender:	Birth Date:	Age:	Last 4 of social:		
Email:	Cell #:	Home #:			
Occupation:	Employer:	May we contact you by: ☐ Cell ☐ Email ☐ Home ☐ Mail			
Current Weight:	Height:				

Emergency Contacts: (please list at least one)		
Name:	Relationship:	Phone #:

Pharmacy Information:		
Name:	Phone #:	City/Zip:

Primary Care:		
Physician Name:	Phone #:	Last Physical:

How did you hear about us?

Women Only:	
Date of Last Menstrual Period:	
Are you pregnant or chance you could be pregnant?	
What are you doing to prevent becoming pregnant?	
Are you lactating?	
Are you menopausal or have you had a hysterectomy?	year
Weight History:	
How old were you when you started to gain weight?	years
Are you aware of any medical reasons for the weight gain?	
How much weight do you want to lose?	pounds
How long do you think it will take you to reach your goal weight?	
How many meals/snacks do you eat per day?	
What is your motivation to lose weight at this time?	

What other programs have you tried?	**Results**	**Why it didn't work for you?**

Have you taken prescription appetite suppressants in the past? Which medication and what were the results?

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Major Health Events/Hospitalizations/Surgeries:

Medication/Drug/Food Allergies:	
Medication/Food	Reaction

Medical Conditions (please check if applicable):							
Past	**Present**	**Family**		**Past**	**Present**	**Family**	
			Acid Reflux				Heart Disease
			Anemia (low blood count)				Heart Disease
			Anxiety/Panic Attacks				Hepatitis Type
			Arthritis				Fibromyalgia
			Asthma				Herpes
			Back Problems				High Blood Pressure
			Binge Eating				High Cholesterol
			Bipolar				HIV/AIDS
			Blood Disorder				Kidney Disease
			Cancer				Knee/Leg Problems
			Chemical Dependency				Migraines Headaches
			Congenital Heart Lesion				Obsessive Compulsive Disorder
			COPD				Osteoporosis
			Depression				Polycystic Ovaries (PCOS)
			Diabetes				Prostate Problem
			Eating Disorder (Anorexia/Bulimia)				Psychiatric Care
			Epilepsy				Respiratory Disease
			Fibromyalgia				Sleep Apnea
			Glaucoma				Stroke
			Gout				Thyroid Problem

Please describe any other medical conditions not listed above:

LIFESTYLE & ACTIVITIES	
Do you have children?	
Do you smoke? If yes, how often?	
Do you drink alcohol? If yes, how often?	
Exercise (frequency and type)	
Do you use street/recreational drugs? If yes, how often?	
Caffeine Intake:	
Current Medications/Vitamins/Supplements:	
Medication History:	

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MEDICATION HISTORY

For your safety and treatment, please circle ANY and ALL medications you are CURRENTLY taking or have been prescribed in the PAST YEAR (12 MONTHS).

☐ Adderall	☐ Demerol (meperidine)	☐ Lorcet/Lortab/Norco/Vicodin (hydrocodone)	☐ Rybix/Rysolt/Ultram/Ultracet (tramadol)
☐ Adipex/Suprenza	☐ Dexedrine/ProCentra (dextroamphetamine)	☐ Lunesta (eszopiclone)	☐ Soma (carisoprodol)
☐ Amrix/Fexmid/Flexeril (cyclobenzaprine)	☐ Didrex (benzphetamine)	☐ Marinol (dronabinol)	☐ Stadol (Butorphanol)
☐ Ambien/Edular/Intermezzo (zolpidem)	☐ Dilaudid/Exalgo (hydromorphone)	☐ Neurontin (gabapentin)	☐ Talacen/Talwin (pentazocine)
☐ Ativan (lorazepam)	☐ Dolophine/Methadose (methadone)	☐ Norflex (orphenadrine)	☐ Tenuate (diethylpropion)
☐ Bontril (phendimetrazine)	☐ Duragesic (fentanyl)	☐ Nucynta (tapentadol)	☐ Toradol (ketoroiac)
☐ Buprenex/Subutex/Suboxone (buprenorphine)	☐ Endocet/Oxycontin/Percocet/ Percodan/Roxicet/Roxicodone/ Tylox (oxycodone)	☐ Opana (oxymophone)	☐ Tranxene (clorazepate)
☐ Codeine	☐ Halcion (triazolam)	☐ Restoril (temazepam)	☐ Valium (diazepam)
☐ Concerta/Metadate/Ritalin (methylphenideate)	☐ Klonopin (clonazepam)	☐ Revia/Vivitrol (Naltrexone)	☐ Versed (midazolam)
☐ Darvocet/Darvon (propoxyphene)	☐ Librium (chlordiazepoxide)	☐ Rozerem (ramelteon)	☐ Xanex (alprazolam)

PHOTO CONSENT & RELEASE

It is inspiring for others to see the success of other individuals just like them who have overcome their struggle with losing weight and keeping it off. We hope that you consider allowing us to use your "before" and "after" images demonstrating your success, as an inspiration to others. Please note that we will never use your image for defamatory, obscene or libelous purposes. I hereby authorize you to use "before" and "after" weight loss photos of me per the following:

_____ **External Use:** Including but not limited to printed flyers, brochures, postcards, posters, advertisements, direct mail, TV commercials, blogs, Facebook & other Social Marketing pages and websites, etc. I acknowledge that my participation is voluntary and that I will receive no financial compensation. I further agree that my participation in any materials produced by West Valley Health & Wellness confers upon me no rights of ownership. I hereby release West Valley Health & Wellness, its owners and employees from liability for any claims by me or any third party in connection with my participation.

_____ **Internal Use Only:** Photos may only be posted inside the clinics on the "before" and "after" success wall or in a picture inside clinic location. I acknowledge that my participation is voluntary and that I will receive no financial compensation. I further agree that my participation in any materials produced by West Valley Health & Wellness confers upon me no rights of ownership. I hereby release West Valley Health & Wellness, its owners and employees from liability for any claims by me or any third party in connection with my participation.

_____ **No Use:** I do give permission to have my photos used for any reason, but acknowledge that the clinic will take before and after photos for my private chart only.

Patient Printed Name _____ Patient Signature _____ Date _____

HIPPA

It is hereby agreed that any and all information, whether written, verbal, literature, protocols or any other communications are considered proprietary and will not be used in any form or shared with any other persons or entities without the expressed written consent of West Valley Health & Wellness. In addition, it is agreed that all patient information is to remain confidential under the guidelines of the Health Insurance Portability Act of 1996.

Patient Printed Name	Patient Signature	Date

B12 INFORMATION AND CONSENT

B12 injections are typically used as a treatment for a certain type of anemia (pernicious anemia). In this type of anemia, people lack intrinsic factor in the stomach which is necessary for the absorption of the vitamin. Vegetarians (especially vegans) are also given shots of B12 since their diet is low in animal products, the primary source of B12. People with chronic fatigue or anemia require monthly injections of vitamin B12 usually because the oral form is not dependable. Vitamin B12 shots are most effective when taken at regular intervals. A regular schedule to receive the injections can be customized to the individual. The body's ability to absorb vitamin B12 is reduced with increasing age. Older people often have a more potent vitamin B12 deficiency, even in cases where they do not suffer from pernicious anemia.

BENEFITS OF B12

- May help increase energy, mental alertness and stamina
- May help boost immune system
- May help increase metabolism
- May help improve mood stabilization
- May help reduce allergies, stress and depression and improve sleep
- May help lessen frequency and severity of migraines and headaches
- May help lower homocysteine levels in the blood, reducing probability of heart diseases and strokes

POSSIBLE SIDE EFFECTS AND CONTRAINDICATIONS OF B12

- A vitamin B12 shot is safe and generally has no side effects.
- Some redness and swelling at the injection site may occur. This should start to get better within forty-eight (48) hours.
- In rare cases, B12 can cause diarrhea, peripheral vascular thrombosis, itching, transitory exanthema, urticarial, feels of swelling of the whole body.
- Sensitivity to cobalt and/or or cobalamin is a contraindication.
- People with chronic liver and/or kidney dysfunction should not take frequent B12 injections.
- Interactions with drugs: Chloramhenicol can impede on the red blood cell producing properties of B12.
- Other drugs that decrease or reduce absorption of B12: antibiotics, cobalt irradiation, colestipol, H2-blockers, metformin, nicotine, birth control pills, potassium chloride, proton pump inhibitors such as Prevacid, Losec, Aciphex, Pantaloc, and Zidovudine.
- B12 is contraindicated in Leber's disease, a hereditary optic nerve atrophic condition.

I have read the information regarding risks and benefits of B12 and/or Lipotropic injections and have had a change to ask questions on the treatment. I have met with a member of the medical staff and understand that the ingredients in the B12 and Lipotropic Injections could include any of the following: B1, B2, B3, B5, B6, B12 Cyanocobalamin or Methylocobalamin, Methionine, Inositol, Choline Chloride, Chromium Chloride, Procaine, Lidocaine, or Benzyl Alcohol. I am not allergic to any of the above ingredients and understand the possible complications of injection therapy are minor bruising and bleeding at injected sites, dizziness, headaches and possible fainting from site of blood. I understand clearly that there may be a slight chance for sensitivities and reactions to injection solutions. I hereby release West Valley Health & Wellness and its staff members and associates from all liabilities regarding my treatment associated with B12 and/or Lipotropic injections.

Patient Printed Name	Patient Signature	Date