



***WELCOME***

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Date: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ (Single Married Divorced Other)  
Last First MI Please circle one

Street: \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

What number would be best to leave an appointment reminder? (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
We use an appointment reminder service.

Parent or Guardian Signature (if patient is a minor): \_\_\_\_\_

Occupation: \_\_\_\_\_ Email: \_\_\_\_\_

Place of employment: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Primary Doctor: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

How did you hear about us? Please check all that apply.

\_\_\_ Paper \_\_\_ Radio \_\_\_ TV \_\_\_ Phonebook \_\_\_ Doctor

\_\_\_ Referral: Please give name: \_\_\_\_\_

## MEDICAL HISTORY QUESTIONNAIRE

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

|    |   |                                       |
|----|---|---------------------------------------|
| A. | Allergies to foods or medications: _____  | <input type="checkbox"/> NONE         |
| B. | Habits:<br>Smoke? Y N      How much? _____<br>Alcohol? Y N      How much? _____ |                                       |
| C. | Family History  |                                       |
|    | Cancer  | Mother _____ Father _____ Other _____ |
|    | Diabetes  | _____                                 |
|    | Heart Disease   | _____                                 |
|    | Hypertension  | _____                                 |
|    | Psychiatric Dis   | _____                                 |
|    | Stroke  | _____                                 |
|    | Obesity   | _____                                 |
|    | Osteoporosis  | _____                                 |

|    |                                     |                               |
|----|-------------------------------------|-------------------------------|
| D. | List all current medications: _____ | <input type="checkbox"/> NONE |
| E. | List all hospitalizations: _____    | <input type="checkbox"/> NONE |
| F. | List all surgeries: _____           | <input type="checkbox"/> NONE |
| G. | Chronic illnesses: _____            | <input type="checkbox"/> NONE |
| H. | Alcoholism or drug problem: Y N     |                               |
|    | If yes, describe: _____             |                               |

**Directions:** Please circle either Y (yes) or N (no) for each question. Answer all of the questions in each section. If you are unsure, circle the truer one.

### Respiratory System

|                               |   |   |
|-------------------------------|---|---|
| Shortness of breath (at rest) | Y | N |
| Night sweats                  | Y | N |
| Productive cough              | Y | N |
| Bloody cough                  | Y | N |
| Tuberculosis                  | Y | N |
| Pneumonia                     | Y | N |
| Emphysema                     | Y | N |
| Asthma                        | Y | N |
| Sleep apnea                   | Y | N |

### Cardiovascular

|                                  |   |   |
|----------------------------------|---|---|
| Chest pain                       | Y | N |
| Hypertension                     | Y | N |
| Heart attack                     | Y | N |
| Heart failure                    | Y | N |
| Heart murmur                     | Y | N |
| Mitral valve prolapse            | Y | N |
| Palpitations (racing heart beat) | Y | N |
| Peripheral vascular disease      | Y | N |
| Edema (swelling of hands/feet)   | Y | N |

### Gastrointestinal

|                 |   |   |
|-----------------|---|---|
| Abdominal pain  | Y | N |
| Heartburn       | Y | N |
| Ulcer           | Y | N |
| Acid reflux     | Y | N |
| Vomiting/Nausea | Y | N |
| Excessive pain  | Y | N |
| Rectal bleeding | Y | N |
| Colitis         | Y | N |
| Gallstones      | Y | N |
| Constipation    | Y | N |
| Diarrhea        | Y | N |

### Psychological

|                            |   |   |
|----------------------------|---|---|
| Depression                 | Y | N |
| Bipolar depressive illness | Y | N |
| Schizophrenia              | Y | N |
| Anxiety/Panic Disorder     | Y | N |
| Panic attacks              | Y | N |

### Neurological

|                  |   |   |
|------------------|---|---|
| Headaches        | Y | N |
| Dizziness        | Y | N |
| Numbness         | Y | N |
| Epilepsy         | Y | N |
| Seizure disorder | Y | N |
| Fainting         | Y | N |

### Genitourinary

|                               |   |   |
|-------------------------------|---|---|
| Enlarged prostate             | Y | N |
| Frequent night time urination | Y | N |
| Blood in urine                | Y | N |
| Burning upon urination        | Y | N |

### Ears, Eyes, Nose, & Throat

|                    |   |   |
|--------------------|---|---|
| Seasonal allergies | Y | N |
| Hearing loss       | Y | N |
| Glaucoma           | Y | N |
| Cataracts          | Y | N |

### Endocrine

|                      |   |   |
|----------------------|---|---|
| High thyroid (hyper) | Y | N |
| Low thyroid (hypo)   | Y | N |
| Diabetes             | Y | N |
| Low blood sugar      | Y | N |
| Gout                 | Y | N |

### Bones, Joints, Muscles

|                       |   |   |
|-----------------------|---|---|
| Aching muscles/joints | Y | N |
| Low back pain         | Y | N |
| Muscle cramps         | Y | N |
| Osteoporosis          | Y | N |
| Arthritis             | Y | N |

### Other

|                  |   |   |
|------------------|---|---|
| Cancer           | Y | N |
| Anemia           | Y | N |
| Fatigue          | Y | N |
| Hot/Cold spells  | Y | N |
| High cholesterol | Y | N |



## CONTROLLED MEDICATION INFORMATION AND CONSENT

### **ANORECTICES (PHENTERMINE, PHENDIMETRAZINE)**

These are a class of medications which help to suppress the appetite and are generally associated with weight loss.

These medications are indicated in the management of exogenous obesity as an adjunct in a regimen of weight reduction based on caloric restriction. These are medications that enhance weight loss by suppressing appetite and increasing metabolism. These medications are used as an aid to your weight loss.

**DO NOT RELY ON THEM TOO HEAVILY!!!  
YOU WILL NOT BE SUCCESSFUL IF YOU DO.**

All of the medications that we use have been proven to be both safe and effective. We do prescribe appetite suppressants that are new to the market. However, their long-term effects are largely unknown. The class of medication, which suppresses the appetite through dopamine/norepinephrine, has proven to be effective and limited side effects are predictable, manageable and reversible.

**PHENTERMINE** comes in various strengths and is dispensed as a tablet or capsule. There are both time-released and short acting formulations. The medication that is prescribed for you will take into account many different factors which the doctor will evaluate. Phentermine is slowly eliminated from the body, usually clearing the body within 4 to 5 days. Side effects include dryness of the mouth, agitation, headaches, irritability, heart palpitations and insomnia. Contraindications include untreated systemic hypertension, heart disease, glaucoma, bipolar depression, psychosis, hyperthyroidism, drug or alcohol abuse and pregnancy.

**PHENDIMETRAZINE** is dispensed as a multi-dose 35mg tablet. This medication is short acting and is usually eliminated from the body within 24 hours. Otherwise, it is essentially the same as Phentermine.

**HUMAN CHORIONIC GONADOTROPIN** is a hormone that is secreted by the placenta during pregnancy. Studies have shown that it may be responsible for fat metabolism or increased fat loss, when used with the proper dietary protocols. While HCG is not approved for weight loss, federal laws do allow for physician to use approved drugs "off-label". This is a common practice in medicine.

**5-HTP/Carbidopa/Levodopa information-**Numerous studies have documented that medications which increase brain serotonin (5-HT) are effective anorectic agents which help obese patients lose weight and which also decrease craving for sweets and carbohydrates. 5-hydroxy-L-tryptophan, abbreviated 5-HTP, is the immediate precursor of serotonin (5-HT). When administered in combination with an inhibitor of peripheral decarboxylase such as carbidopa, 5-HTP increases brain serotonin. Increases in synaptic 5-HT decreases the firing rate of 5-HT neurons via stimulation of inhibitory 5-HT<sub>1a</sub> receptors located on the cell bodies in the raphe. This serves as a negative feedback loop. The use of carbidopa as an off-label application with 5-HTP has demonstrated increased weight loss in subjects. The novel aspect of the invention are the doses of the 5-HTP and carbidopa: much lower daily doses than have been used before are effective in decreasing appetite, decreasing craving for food and for promoting weight loss. Side effects of 5-HTP may include nausea, headaches, vomiting, constipation, and gas. Patients who are taking MAO inhibitors such as Pamate, Nordil, or Morplan and patients who have severe arrhythmias should not take these medications. Never take more than a ¼ tablet of carbidopa in a single dose.

As with any medication, some people may experience side effects. The most common reported side effects in women were breast tenderness and changes in menses. Contraindications include a history of breast cancer, ovarian cancer, endometrial cancer and testicular cancer in men. Anyone with a past history of the conditions listed should not take HCG.

**If you experience any problems with the medications or any other aspect of our program, please CALL OUR OFFICE.** We will be glad to assist you any way that we can.

#### **As a condition of treatment;**

- 1. I understand that the FDA for use as a treatment for obesity has approved some of the medications listed above.**
- 2. I agree to follow all of the guidelines set and to take my medications as prescribed by Dr. Morris.**
- 3. I have been informed of the possible side effects that may accompany my treatment with the medications.**
- 4. 5-HTP/Carbidopa/Levodopa- I have reviewed the information pages and understand its uses, effects, side effects and contra indications for use. I understand this is an "off label" usage of these medications.**
- 5. I understand that I may get my prescriptions filled at a pharmacy of my choice.**

**I fully understand and agree to all conditions set forth in my treatment and agree to all of the above statements.**

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Or Parent or legal guardian if a minor.**

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I hereby give my consent for Complete Wellness to use and disclose protected health information about me to carry out treatment, payment, and healthcare operations.

With this consent, Complete Wellness may call, mail, and email to my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. Any mailed items should be marked personal and confidential.

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- \* Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- \* Obtain payment from third-party payers.
- \* Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at 1800 Nations Dr. ste. 101, Gurnee, IL. to obtain a current copy of the Notice of Privacy Practices.

I have the right to request in writing that Complete Wellness restrict how it uses or discloses my protected health information to carry out treatment, payment, and healthcare operations.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Complete Wellness use and disclosure of my protected health information to carry out treatment, payment, and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Complete Wellness may decline to provide treatment to me.

**CONSENT FOR CARE**

I agree to treatment and intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

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

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

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

**COMPLETE IF PATIENT IS A MINOR CHILD.**

I, \_\_\_\_\_, being the parent or legal guardian of \_\_\_\_\_, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive care at Complete Wellness.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this form, but was unable to do so as documented below:

|       |           |         |
|-------|-----------|---------|
| Date: | Initials: | Reason: |
|-------|-----------|---------|



199 S. Addison Road, Suite 105, Wood Dale IL 60191  
1800 Nations Drive, Suite 101, Gurnee IL 60031  
[www.cwmcillinois.com](http://www.cwmcillinois.com) / 1-877-LIPOLOSS

## AUTHORIZATION TO RELEASE INFORMATION

I AUTHORIZE PHYSICIAN \_\_\_\_\_ TO RELEASE TO:

( ) 199 S. Addison Road, Suite 105, Wood Dale, Il 60191 Fax (630) 766-4220

( ) 1800 Nations Drive, Suite 101, Gurnee, IL 60031 Fax (847) 263-0590

\_\_\_\_\_ PATIENT RECORDS FOR MYSELF OR MY CHILD.

\_\_\_\_\_ PATIENT MOST RECENT BLOOD WORK RESULTS AND EKG.

PATIENT'S NAME: \_\_\_\_\_

PATIENT'S DOB: \_\_\_\_\_ PHYSICIAN'S CITY: \_\_\_\_\_

REQUESTING DOCTOR: Scott D. Morris, M.D.

PATIENT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_