PLATINUM WELLNESS

Be Transformed by Renewing Body and Mind

Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Sex: [M] [F] Age: _____ Birth date: _____ Height: _____ Weight: _____

Marital Status: □ Single □ Married □ Widowed □ Separated □ Divorced

Occupation: _____ Hobby: _____

Who may we thank for referring you? _____ Current MD. _____

Medical Prescriptions: _____

Prior Surgeries: _____

Has your doctor advised you to lose weight? □ Yes / □ No How much? _____ lbs.

Do you have any dietary restrictions? □ Yes / □ No

Known Adverse Reactions to niacin or B vitamins? □ Yes / □ No

Do you suspect you have a Thyroid Condition? □ Yes / □ No

My energy on a 1-10 scale Low 1 2 3 4 5 6 7 8 9 10 Very High

How important is it for you to become healthy/lose weight? 1 2 3 4 5 6 7 8 9 10

Do you experience? (Circle) Bloating, Reflux, Constipation, Diarrhea, Indigestion

Please tell us your current health goals

_____

_____

_____

What do you consider your ideal weight? _____

When was the last time you were at your goal weight? _____

How many times a year do you diet? _____

What is stopping you from losing weight all on your own? _____

Does your weight problem make you physically uncomfortable or cause pain? □ Yes / □ No

Are you embarrassed by your excessive weight? □ Yes □ No

Please explain: _____

How much weight do you want to lose? _____

Does being overweight and unhealthy limit your activities? □ Yes □ No

Please explain: _____

Do you binge eat? □ Yes □ No

Do you suffer from uncontrollable cravings? □ Yes □ No

Do you feel food controls you? □ Yes □ No

Do you eat for emotional reasons (stress, anger, sadness, etc.)? □ Yes □ No

Briefly describe your daily eating behavior: _____

Do you feel your eating behavior is normal? □ Yes □ No

How fast do you want to be slim, trim, and fit? _____

What's more important to you fast or permanent? _____

Is your family excited about you coming here for weight loss? □ Yes □ No

Can you remember being your ideal weight? □ Yes □ No

What do you remember most about it? _____

_____

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Y / N	General Health Assessment
☐ ☐	Do you frequently feel tired?
☐ ☐	Does fatigue alter your lifestyle?
☐ ☐	Intestinal gas?
☐ ☐	Abdominal bloating?
☐ ☐	Crave sugar?
☐ ☐	Crave beer, wine or bread?
☐ ☐	Constipation or diarrhea?
☐ ☐	Irritable or easily angered?
☐ ☐	Faint, dizzy or lightheaded?
☐ ☐	Muscle aches?
☐ ☐	Weight gain?
☐ ☐	Loss of sexual desire?
☐ ☐	White or yellow fuzzy tongue?
☐ ☐	Athlete's foot, ringworm or jock itch?
☐ ☐	Fungus of toenails or fingernails?
☐ ☐	Bothered by perfumes/chemical smells?
☐ ☐	Ever take antibiotics?
☐ ☐	Using birth control (or have you)?
☐ ☐	On synthetic hormones?
☐ ☐	Itching or burning of vagina, rectum or prostate?
☐ ☐	Every taken steroids for allergies, asthma or injuries?
☐ ☐	Trouble thinking clearly and/or short term memory loss?

Just curious, which is the most important for you? (Please check ONE)

☐ **EFFECTIVENESS** "*My results are my top priority*"
☐ **TIME** *"I want results quickly"*
☐ **SERVICE** *"I will need extra support along the way"*
☐ **AFFORDABILITY** *"Cost is my major concern"*

Thyroid Function Assessment	Y / N
Do you have severe fatigue and find it hard to get up in the morning?	☐ ☐
Do you have generalized low energy?	☐ ☐
Do you need caffeine and/or other stimulants to get you going?	☐ ☐
Do you have a family history of thyroid disease?	☐ ☐
Do you gain weight easily?	☐ ☐
Have you had difficulty losing weight in the last 2 years?	☐ ☐
Do you have dry skin?	☐ ☐
Do you have constipation?	☐ ☐
Are your menstrual cycles irregular?	☐ ☐
Do you suffer from mood swings?	☐ ☐
Is your hair thinning?	☐ ☐
Is your hair dry/brittle?	☐ ☐
Do you have low sex drive?	☐ ☐

Do you have high cholesterol?
Do you have low blood pressure?
Do you suffer from depression?
Are the outer third of your eyebrows missing or thinning?
Do you have any problems with remembering things?

Stress Assessment/Adrenal Function

Do you have a close support network of family and friends?
Are you happy with your current job/profession?
Do you consume caffeine, sugar or refined carbohydrates?
Are you comfortable financially?
Are you satisfied with your life and its direction?
Do you keep your weight within normal range easily?
Do you get 8 hours of uninterrupted sleep per night?
Are you frequently anxious, depressed, or have panic attacks?
Would you rate yourself as stressed?
Do you have trouble falling asleep?
Are you more tired after exercise?

Toxic Burden Assessment

How many fast food meals do you eat each week? ☐ None ☐ 1-2 meals ☐ 3 or more meals

Y / N

Do you consume 'diet foods' sweetened with aspartame, Splenda or saccharin?
Do you tend to overeat?
Do you regularly consume foods preserved with MSG (mono-sodium glutamate)?
Do you eat foods that are artificially colored?
Do you eat only organic produce? (Grown with no pesticides)
How many different colors of vegetables & fruits do you eat in a day?
Do you have an excessive consumption of sodas, coffee (two cups a day)?
Do you drink 8-10 glasses of filtered, spring or mineral water every day?
Do you experience GI distress? (gas, bloating, diarrhea, constipation)
Do you consume alcohol? ☐ No ☐ Yes 1-4 / week ☐ Yes 5 or more/week
Do you regularly use prescription or over the counter (OTC) medication?
How many hours a day do you spend in front of a computer? < 1 2 3 4 5 6 7 >

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Have you had ANY of the following? (C for current X for in last 12 months)

GENERAL-Pregnant___Pacemaker___Cancer___Hyperthyroid___Hypothyroid___
Epilepsy____ Dizziness ____ Fainting ___ Fatigue ____ Fever ____ Headache ____ Loss of Sleep ____
Allergy ____ (to what_____) Loss of Weight ____ Nervousness ____ Wheezing ____ Bronchitis ____
Numbness in BOTH hands AND feet ____ Currently Undergoing Chemotherapy _____

CARDIOVASCULAR
Blood Thinners _____High Blood Pressure ____ Low Blood Pressure ____ Heart Disease _____ Poor Circulation ____
Rapid Heartbeat ___ Previous Heart Problem ____ (Describe _____) Slow Heartbeat ____
Stroke ____ TIA ____ Swollen Ankles ____ Varicose Veins ____ Aortic Aneurysm ____ Bruise Easily ____

DISEASES/CONDITIONS
Appendicitis ____ Anemia ____ Arthritis ____ Alcoholism ____ Bleeding Disorder ____ Blood Clot(s) ____
Breathing Difficulty ____ Cancer ____ Cholesterol High ____ Colon Problems ____ Diabetes ____ Depression ____
Eczema ____ Eating Disorder ____ Glaucoma ____ HIV + ____ Heart Disease ____ Kidney Disease ____
Liver Disease ____ Mental Illness ____ Prostate Problems ____ Hyperthyroid ____ Hypothyroid ____
Rectal Surgery ____

EARS/EYES/NOSE/THROAT
Asthma ____ Crossed Eyes ____ Double Vision ____ Blurred Vision ____ Difficulty Swallowing ____Deafness ____
Hearing Loss ____ Ear Pain ____ Thyroid Problem ____ Nose Bleeds ____ Sinus Problems ____ Sore Throats ____

GASTRO-INTESTINAL
Gas ____ Colon Trouble ____ Constipation ____ Diarrhea ____ Gallbladder Trouble ____ Hemorrhoids ____
Liver Trouble ____ Nausea ____ Stomach Ache ____ Poor Appetite ____ Poor Digestion ____ Vomiting ____
Rectal Bleeding ____ Bloating ____

GENITO-URINARY
Blood in Urine ___ Frequent Urination ___ Inability to control urine ____ Kidney Infection ____ Painful Urination ____

FOR MEN ONLY
Lump in testicles ____ Penis discharge ____

FOR WOMEN ONLY
Currently Pregnant _____ Breast Feeding _____ Menstrual Cramps ____ Excessive menstrual flow ____
Hot Flashes ____ Irregular Cycle ____ Painful periods ____ Birth Control Pills ____ Abnormal Pap Smear ____

MUSCLE/JOINT/BONE
Backache ____ Foot Trouble ___ Pain Between Shoulders ____ Painful Tailbone ____ Stiff Neck ____
Spinal Curvature ____ Swollen Joints ____ Low Back Pain ____

NEUROLOGIC
Seizures ____ Dizziness ____ Hand Trembling ____ Weakness ____ Loss of memory ____
Loss of coordination ____

RESPIRATORY Chest Pain ____ Chronic Cough ____ Difficulty Breathing ____

Consent Form

(The Not So Fine Print)

The Health Part

As you can imagine, results on a program of this nature vary and cannot be guaranteed. Recommended supplements, herbs, etc. are intended to work with specific diet/lifestyle changes, which are a critical part of the process. (So no cheating!) In general, you will get out of it what you put in.

All supplements, vitamins, herbs recommended are generally considered safe, however, some can interact with certain medications, so please consult with your prescribing physician before beginning program. If currently taking medications, please don't stop without consulting with your doctor. If you have a high/low blood pressure or sugar, please monitor it carefully because as your health improves, you may need to speak with your doctor about adjusting medications accordingly. Every precaution is taken to ensure safety. Our programs and supplements have helped thousands achieve their goals, however, we cannot predict how each person will respond to each supplement (allergies, etc.). Therefore, you are acting at your own risk. Please advise us and your doctor if necessary, if you experience any unpleasant or unanticipated side effects including gastrointestinal upset, allergic reactions, etc. We do not diagnose or treat diseases including but not limited to diabetes, heart disease, cancer, autoimmune, thyroid disease, etc. We treat people. Your signature indicates that you authorize the staff to perform any necessary services, and that the above information was completed correctly to the best of your knowledge. It is your responsibility to inform this office of any changes to the information you have provided.

The Unavoidable Money Part

Your signature below indicates that you understand that you are solely responsible for any treatment rendered in this office. We cannot accept insurance for weight loss services.

The Most Important Part

Ultimately, great communication is the key to any great, long lasting relationship. If something is on your mind, from symptoms you experience to ways we can improve our services, please let us know! You can reach Dr. Infantino directly on his cell number 480-452-8355 to share a win, make a suggestion or just to give him feedback. We truly look forward to serving you. Welcome to our family!

_____

Signature

***How we protect your Health Information*:**

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR HEALTHCARE PURPOSES

By signing this Consent, I acknowledge and provide permission to Platinum Wellness (Practice) as follows:

1. Platinum's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Con-sent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice:

a) A postcard mailed to me at the address provided by me; and b) telephoning my home and leaving message
on my answering machine or with the individual answering the phone.

4.The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or dis-closed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice reserves the right to not treat me.

I have read and understand the health information disclosure and protection in the foregoing notice.

_____ _____

PRINTED Name SIGNATURE

_____

DATE

_____ _____

Signature of Legal Guardian (e.g. if a minor) Relationship to minor