Jeff Blixt D.O., Inc.
1715 N. Weber Street
Suite 260
Colorado Springs, CO 80907

New Patient Intake Form

Full Name: _____

Address: _____ Apt#:_____

City: _____ State: _____ Zip:_____

Date of Birth: _____

Email Address:_____
(For Appointment Reminders Only)

☐ Consent to voice/text messaging
(For Appointment Reminders Only)

☐ Do not consent to voice/text messaging

Our office cares about our client's privacy and will protect the confidentiality of your medical information. Due to current State and Federal Laws regarding our office's responsibility to protect your information, you may request a copy of our Notice of Privacy Practices. Just ask our front desk for a copy.

Signature: _____ Date:_____

By signing on the above line, you agree to have been notified that our office has a privacy policy in place and have been allowed a copy of these policies. If you have any questions regarding our policies, please ask our office staff.

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Dear Client, Date:_____

Our office has adopted a policy that requires my office staff to obtain an authorization from you so we may contact you regarding appointments, test results, and account information. In an effort to protect your privacy and follow federal guidelines, please complete the following information:

I, _____, give permission for Dr. Blixt or his office
(Print name)
staff to leave a phone message regarding my medical care/account information. I fully

understand that this consent will remain valid unless revoked in writing by me.

Where can we leave a message for you?

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Is there anyone else we can leave this information with on your behalf?

Spouse/Partner: if yes, Name:_____
Phone Number:_____

Child: if yes, Name:_____
Phone Number:_____

Other: if yes, Name:_____
Relationship:_____
Phone Number:_____

Any special
instructions?_____
_____

Signature: _____ Date:_____

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Due to a high rate of clients not showing up for their scheduled appointments, I have found it necessary to charge a fee of $20.00 for these missed appointments. If you are unable to make your appointment, we require a 24-hour notice of your cancellation. We understand that unforeseen circumstances arise. However, we still need you to call as soon as possible. Clients that have 3 or more no-shows in a 12-month period will be dismissed.

Another concern I have is clients being late for their appointments. I understand that some of you drive a long distance. Unfortunately, when you are late for your appointment, the clients that arrive on time are not able to be seen at their scheduled time. Therefore, if you will be arriving late for your appointment, please notify my office staff at 719-896-4794. You may be informed that you need to wait until we can get you in, or you may need to be rescheduled.

I understand Dr. Blixt's Policy:

Signature: _____ Date:_____

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Weight Loss Intake Form

Full Name: _____

Date of Birth: _____

Primary Care Physician: _____

List all medications with dosage:

Allergies to medications:

Please check to indicate if you have ever had the following conditions:

- ☐ Arrhythmia
- ☐ Arthritis/Degenerative Joint Disease
- ☐ Asthma
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Eye problems
- ☐ Heart attack
- ☐ Hepatitis
- ☐ Kidney disease
- ☐ High blood pressure
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Problems

Do you have regular menstrual cycles?: No
If no, explain:

Please list any major surgeries or hospital stays you have had and their approximate date/year:

If you have any other medical problems or serious injuries that are not listed above, please describe them here:

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When was your last physical?: _____

Please specify any family members who are overweight?:

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

- ☐ Asthma
- ☐ Epilepsy
- ☐ Diabetes
- ☐ Heart Disease/ Stroke
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Obesity
- ☐ Psychiatric Disorder
- ☐ Tuberculosis

Any additional family history information you wish to share:

Present Weight: _____
Height:(no shoes) _____
Desired Weight: _____

In what time frame would you like to be at your desired weight?:

Birth Weight: _____
Weight at 20 years of age: _____
Weight one year ago: _____

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

When did you begin gaining excess weight?:(Give reasons, if known):

What has been your maximum lifetime weight (non-pregnant) and when?:

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Previous diets followed in the past. Please give dates and results of your weight loss:

Previous medication (prescribed) or supplements (over the counter) taken for weight loss: Give dates and any side effects:

Do you smoke, or use tobacco products?: If yes, how often?:
Previous Smoker?: If yes, how long ago?:

How often do you have a drink containing alcohol?:
How manv drinks containing alcohol do you have on a typical day when you are drinking?:

When you are in a stressful situation at work or family related do you eat more?: Please explain?:

Do you think you are currently undergoing a stressful situation or an emotional upset?: Please explain?:

Do you eat out?:
What restaurants do you frequent?:
Do you plan your own meals, cook and shop?:
Do you use a shopping list?:
What time of day and on what day do you shop for groceries?:
Identify foods that you crave:

Do you drink coffee or tea daily?: How much?:
Do you drink soft drinks?: How many and how often?:
Do you use sugar substitute?:
Do you wake during the night?: If so, do you eat?

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What is your worst food habit?

What are your snack habits?: How much? When?:

Do you eat breakfast?: No
If so, what?:

What is a typical lunch?: Time eaten, with whom, where?:

What is a typical dinner?:Time eaten, with whom, where?:

Describe your activity level:
Describe your behavior style:

Describe your general health goals and improvements you wish to make?:

Marital Status:
Children?: If yes, how many?:
Occupation:

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Patient Informed Consent for:
Weight Loss Program and Appetite Suppressant and/or other Medication Use

I. **Procedures and Alternatives:**

1. I, _____ (client, or client's guardian) authorize Dr. Jeff Blixt to assist me in my weight reduction efforts. I understand my treatment may consist of a balanced deficit diet, a regular exercise program, and instruction in behavior modification techniques and may involve the use of appetite suppressants and/or other medications. I further understand that if appetite suppressants and/or other medications are used, they may be used for durations exceeding those recommended in the mediation package insert. And when indicated, in higher doses than the dose indicated in the appetite suppressant and/or other medication labeling.
2. I understand that it is my responsibility to follow the instructions carefully and to report to Dr. Jeff Blixt, treating me for my weight, any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.
3. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this loss. I understand my continuing to receive the appetite suppressant and/or other medication will be dependant on my progress in weight reduction and weight loss.
4. I understand that there are other ways to and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss without utilizing weight loss medications.

II. **Risk or Proposed Treatment:**

I understand this authorization is given with the knowledge that the:

1. Use of appetite suppressants for more than 12 weeks and in higher doses than the doses indicated in the labeling involves some risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heartbeat and heart irregularities. Less common but more serious risk are: primary pulmonary hypertension, valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

I have read and understand my doctor's statement that follows:

Medication, including the appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, amon other things, suggestions for using this medication. The appetite suppressant labeling suggestions are generally based on shorter term studies (up to 12 weeks) using the dosages indicated.

As a bariatric physician, I have found the appetite suppressants helpful for periods far in excess of 12 weeks, and at times in larger doses than those suggested in the labeling. As a physician, I am not required to use the medication as the labeling suggests, but I do use labeling as a source of information along with my own experience, the experience of my colleagues, recent longer term studies, and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time, and at times, in increased doses.

Such usage has not been systematically studied as that suggested in the labeling and it is possible as with most other medications, that there could be serious side effects (as noted above).

As a bariatric physician, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant use for longer periods of time when indicated, in increased doses. However, you must decide if you are willing to accept the risks of side effects, even if they might be serious, for the possible help the appetite suppressant use in this manner may give.

III. Risks associated with Being Overweight or Obese

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, diabetes, heart attack, heart disease, and arthritis of the joints, hips, knees, and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am.

IV. No Guarantee

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

V. Patient's Consent

I have ready and fully understand this consent form and I realize I should not sign this form if all items have not been explained or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form, and in talking to Dr. Blixt regarding the risks associated with the proposed treatment, and regarding other treatments not involving the appetite suppressant and/or other medications.

Client Name: _____

Signature: _____ Date: _____

VI. Physician Declaration:

I have explained the contents of this document to the client and have answered all of the client's related questions, and to the best of my knowledge, I feel the client has been adequately informed concerning the benefits and risks associated with alternative therapies and the risks of continuing in an overweight state. After being adequately informed, the client has consented to therapy involving the appetite suppressants and/or other medications in the manner indicated above.

Jeff Blixt's (Physician's) Signature: _____