Weight Loss Confidential Client History & Consent Form

Date:___________________ Name: ________________________________ Date of Birth:__________________

Email address:____

Address:_____________________________________ City:________________ St:_______Zip:________________

Home/Cell Phone:_______________________________________Is texting ok? ____________________________

Emergency Contact:____________________________________ Phone:__________________________________

Primary Physician Name:_________________________________ Date of last physical exam: __________________

Have you ever been told your labwork was abnormal? ____

Preferred Pharmacy name and address:____

Current weight___________ Current Height____________ Goal Weight__________ Blood Pressure __________

1) Have you been under the care of a medical professional within the past year? ○No ○Yes ___________________

2) Any recent surgery, including plastic surgery? ○No ○Yes, explain____

3) Have you had any of the following health conditions in the past or present?

Cancer	☐	Headaches	☐
Hormone Imbalance	☐	Hepatitis	☐
High/low blood pressure	☐	Fever blisters/cold sores	☐
Thyroid Problems	☐	Diabetes	☐
Poor circulation	☐	Elevated Blood Sugar	☐
Heart problem/CV disease	☐	Insomnia	☐
Skin diseases/skin lesions	☐	Elevated Blood Pressure	☐
Any active infections	☐	Mood Disorder	☐
Asthma	☐	Alcohol or Drug Abuse	☐
Eating disorders	☐	Depression on medication	☐

4) Do you smoke? ○ No ○ Yes If yes, what and how much? ____

5) Do you follow a restricted diet? ○ No ○ Yes

6) What is the most you have ever weighed and when? ____

7) List any medications, supplements and vitamins and doses you are taking regularly:

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8) List any allergies: ____

9) Do you or anyone in your family have Diabetic retinopathy, low blood sugar, gallbladder disease, pancretitis, decreased kidney function, Medullary Thyroid Cancer, MEN 2 (multiple endocrine neoplasia type 2) or a family history of medullary thyroid carcinoma ____

Exercise routine:

____

List any weight loss methods you have already tried with or without success (special diets or cleanses, weight watchers, calorie counting, gym membership, medications)

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Female Clients Only: Are you pregnant or trying to become pregnant? ○No ○Yes

I understand, have read, and fully completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. While all treatments are recommended to achieve the best possible results, I do understand that not all treatments will have the same results on every client, therefore no guarantee can be given. I also understand that withholding information or providing misinformation in this form and any communications with Ericsson Aesthetics or any of their staff may result in contraindications to medications or treatments prescribed. I am aware that it is my responsibility to inform the provider my current medical or health conditions and to update this history as applicable. The services/medications/injections I receive here are voluntary and I release Ericsson Aesthetics, LLC from liability and assume full responsibility thereof. I also understand approval from my primary Medical Doctor should be obtained before starting any diet or exercise program. I understand payment is due in full at the time of beginning the program and is not refundable under any circumstancess.

I authorize Ericsson Aesthetics to help me in my weight-reduction efforts. I understand that my program may consist of a balanced-deficit diet, a regular exercise program, instruction on behavior modification techniques, and may involve the use of on and off label anti-obesity medications or other medications that have been approved by the FDA. Other treatment options may include a very low-calorie diet or a protein supplemented diet. I further understand that if medications are used, they have been used safely and successfully in private medical practices with experienced obesity medicine specialists as well as in academic centers for periods exceeding those recommended in the product literature. I understand that any medical treatment may involve risks as well as the proposed benefits and no refunds are ever issued. I also understand that there are certain health risks associated with having excess weight or obesity. Risks of this program are usually temporary, reversible, and may include but are not limited to nervousness, sleeplessness, headaches, electrolyte abnormalities, dry mouth, gastrointestinal disturbances, weakness, fatigue, pancreatitis, psychological problems, gallstones, high blood pressure, rapid or slowing of the heartbeat and heart irregularities, and risk of weight regain. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints, including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight but will increase with additional weight gain over time. I understand that much of the success of the program will depend on my efforts and that there are no guarantees that the program will be successful. I also understand that obesity is a chronic, lifelong condition that may require changes in eating habits and permanent changes in behavior to be treated successfully. I have read and fully understand this consent form and it has been fully explained to me. My questions have been answered to my complete satisfaction and I understand my program is valid for 3 months from today, however may be renewed upon successful completion of the program, with approval from the providers. I agree to monitor my blood pressure and heart rate and other vital signs at least monthly and report any changes to the provider, regardless of belief that it may or may not be related to the program. I understand that any and all texting or emailing of personal information may not be sent in a secure manner; if I desire complete security, I will communicate live, over the phone or in person or via fax at 888-981-1831. Emailing and texting is at my discretion, and if I authorize my providers to respond in a like manner for any unsecure communications received.

Client signature: ____ Date:__________________