Weight Loss Self-Assessment & Consent to Treat

Patient Name:_____DOB:_____

When did weight become a problem for you?

_____

What do you think is the cause of your weight problem?

_____

_____

Highest weight in the past_____Lowest weight in the past_____

Please list the factors you feel have contributed to your current weight (check all that apply):

____Slow metabolism

____Family History of Obesity

____Comfort food and dependency

____Addiction to food

____Lack of exercise

____Binge eating

____Late night snacking

____History of trauma

____History of grief and loss

____Medication related

____Disordered eating such as restriction, binging, and/or purging

____Other:

____Other:

Medical History

Please list any medical conditions you have been diagnosed with:

_____

_____

_____

Please list all surgeries/medical procedures/inuries you have had and the year:

Please list all medications you are on:

Name of Med	Dosage	How often do you take	How long have you taken

How much exercise do you get and how often?

What are your sources of stress?

How do you manage your stress?

Do you have people close to you who support you?

Diet and Lifestyle

Do you regularly drink alcoholic beverages?

_____

If yes, how many per week?

_____

Do you use tobacco? How much?

_____

Do you use recreational drugs?

_____

How is your appetite?

_____

Do you binge eat? (Eat a large amount of food in a small amount of time, feel out-of-control while doing it, eat when not hungry, eat until uncomfortably full, feel regret/shame/guilt afterword?)

Yes No

Snack habits:

What do you snack on? How much?

_____

When do you typically snack?

_____

Typical Meals

Meal	What do you typically eat?	How much?	When do you typically eat?
Breakfast			
Lunch			
Dinner			

How often do you eat out?_____

What restaurants do you frequent?_____

___

How often do you eat fast foods?_____

__

Do drink caffeine? If yes, how much daily?

_____

Do you drink soda? If yes, what kind and how much daily?

_____

Do you use sugar or sugar substitues?

_____

What are your worst food habits?

_____

How much fluids do you normally drink? Please approximate in ounces.

_____

Please list all types of beverages you regularly drink.

_____

Please list any food allergies, intolerances, or food you avoid and the reason.

_____

_____

_____

What struggles and difficulties have you experienced in terms of food and dieting?

_____

_____

_____

What diet and exercise programs, protocols, plans, or approaches have you tried in the past? Were they successful or unsuccessful?

_____

_____

Please provide any additional information that you feel is important to share:

Medications for Weight Loss

Please circle any medication that you have tried previously to lose weight. Let us know if it worked, didn't work, or you had side effects.

Medication	Did it help?	Side effects	Other
Phendimetrazine			
Phen/Phen			
Phentermine			
Qsymia (Phentermine/Topiramate)			
Contrave (Bupropion/Naltrexone)			
Topiramate			
Naltrexone			
Metformin			
Alli (Orlistat)			
HCG injections			
Wellbutrin/Bupropion			
Naltrexone			
Vyvanse			
Evekeo			
Saxenda/Liraglutide			
Ozempic/Semaglutide			
Wegovy/Semaglutide			
Mounjaro/Tirzepatide			
Zepbound/Tirzepatide			
Other(s):			

Consent for Treatment

____Phentermine, Evekeo, and Vyvanse are considered controlled substances. I agree that I will take my medications as prescribed. I agree to follow my medical providers instructions.

____I will not sell or share my prescriptions to other individuals.

____I acknowledge that Norman Psychiatry, APRN-CNP, PLLC and my provider are not my primary care provider. I will continue with routine care through my primary care provider and notify them of treatments prescribed.

____I understand there are no refunds for services or products rendered. We cannot accept back medications once they have been dispensed per state regulation.

____I agree that if I am having side effects of become sick, that I will contact my provider or go to an urgent care of emergency department.

____I do not hold any medical practitioner of Norman Psychiatry, APRN-CNP, PLLC responsible if an adverse event occurs during my treatment.

____I acknowledge that I am voluntarily entering into a medically managed weight loss program with Norman Psychiatry, APRN-CNP, PLLC. I fully realize that entering any program involving weight reduction, which includes moderate calorie restriction, exercise, and medications, involves potential risks and side effects. The risks include, but may not be limited to the following:

Cardiovascular (heart or blood pressure): These problems may include heart palpitations, irregular beats, or rapid heartbeat. These effects are usually mild but can result in serious problems including heart attack or stroke. Also, some medications may increase blood pressure, which if left untreated can lead to heart attack or stroke. For this reason, if you are on blood pressure medications you are required to monitor your blood pressure daily and discontinue medications if blood pressure or heart rate increases, or you feel palpitations.

(Please initial)_____

Sudden Death: Patients with obesity, particularly those with hypsertension, heart disease, or diabetes, have a statistically higher chance of suffering sudden death when compared to normal weight people without such medical problems. Rare instances of sudden death have occured while obese patients were undergoing medically supervised weight reduction, though no cuase and effect relationship with treatment has been established.

(Please initial)_____

Reduced Potassium or other Electrolyte Levels: Failure to consume adequate food and fluids can cause electrolyte disturbances

(Please initial)_____

Gall Bladder Disease/Pancreatitis: Any program resulting in rapid weight loss my cause gallbladder or pancreas issues including gallstones, pain, and may require surgery. If you experience some of the common side effects, such as nausea, vomiting, constipation, etc. I will contact the prescriber. I understand that not addressing severe constipation could lead to a bowel obstruction and be a medical emergency.

(Please initial)_____

Psychiatric: Some medications can cause psychiatric symptoms including depression, anxiety, mania (less sleep, expansive mood, impulsiveness, euphoric or irritable mood)

(Please initial)_____

Pregnancy (Females only): If you become pregnant during treatment, inform your provider immediately due to possible risks to a fetus. You must take precaustions to prevent pregnancy during you treatmet

(Please initial)_____

The use of medications for weight management is indicated for those patients who have a BMI of 30 or higher or a BMI of 30 or more or a BMI of 27 or higher with other medical conditions. Prescribing medications not fitting these criteria is considered "off label" and not "FDA approved." Many of these medications are not approved for weight loss purposes, but have been shown to help with weight loss due to reducing food cravings or decreasing appetite. Therefore, the potential risks vs. benefits must be evaluated with your provider. If I proceed with treatment, I have determined the benefits outweigh the risks.

(Please initial)_____

You acknowledge that alcohol and illlicit drug use is prohibited in the program. Drugs like cocaine and amphetamines when used in conjunction with appetite suppressants and other medications prescribed could cause serious injury or death. The use of alcohol and marijuana can also negatively affect your results.

(Please initial)_____

I understand that the amount of weight loss varies from patient to patient, and is, to a large extent **DEPENDENT ON EACH PATIENT'S PERSONAL MOTIVATION and COMMITMENT** to their diet and exercise plan. No claims as to efficacy or specific amount of weight loss is either expressed, implied, or guaranteed. I understand that it **WILL TAKE MORE THAN JUST MEDICATION for me to lose weight.** I must make changes in my diet and exercise to

be successful.

(Please initial)_____

I agree that I have read all the above statements that I have initialed, including risks, and agree to treatment. I understand that there are possible additional risks not listed as every patient is an individual and may have side effects that are outside the normal reaction by most people. I agree that I will contact my prescriber if I experience adverse reactions to my medication or treatment plan.

Patient Name:_____

Patient Signature:_____

Date:_____