LIFESTYLE MEDLY
+201-844-9062
support@lifestylemedly.com
441 US-130, East Windsor, NJ 08520

Lifestyle Medly Patient Intake & Registration Form

Welcome to Lifestyle Medly! To ensure your safety and program suitability, we need some personal and health information about you. We take your privacy seriously and treat all information confidentially.

DEMOGRAPHIC DATA

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: □ M □ F

Home Address: _____

Home Phone: _____ Mobile: _____

Race *(i.e., White, Asian, African American):* _____ Hispanic Latino: □ Yes □ No

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

Occupation: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact
Name/Relationship: _____ Phone: _____

List all your current medications: _____

_____

Drug Allergies, if any: _____

How did you hear about us? _____

MEDICAL INFORMATION		
Do you have:		**If yes, pls provide further details:**
Have you ever had an allergic or adverse reaction to vitamins?	□ YES □ NO	
Are you currently taking any blood thinners?	□ YES □ NO	
History of pancreatitis?	□ YES □ NO	
History of inflammatory bowel disease, such as Crohn's Disease	□ YES □ NO	
Gall-bladder disease or surgery?	□ YES □ NO	
History of cardiovascular diseases, such as: Hypertension?	□ YES □ NO	
Hyperlipidemia?	□ YES □ NO	
Sleep Apnea?	□ YES □ NO	
Osteoarthritis (OA)?	□ YES □ NO	
Have you experienced mental health issues or had any suicidal attempts?	□ YES □ NO	
Are you planning to have surgery in the near future?	□ YES □ NO	
Are there any other significant medical events or surgeries in your past?	□ YES □ NO	

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I. Do you have:		If yes, pls provide further details:
For Females: Are you pregnant, breastfeeding or planning to become pregnant?	□ YES □ NO	
Are you using contraception to prevent pregnancy?	□ YES □ NO	
Do you use tobacco?	□ YES □ NO	
Do you consume alcohol? How much?	□ YES □ NO	

I. Background and Motivation	Responses
Current Weight & Height	Weight: Height:
Highest Adult Weight	
Lowest Adult Weight	
What is your biggest struggle when it comes to managing your weight? A. Craving B. Lack of Exercise C. Maintaining poor sleep habits	
What methods have you tried to lose weight in the past?	
What if any medications have you used?	
Did you experience any complications or side effects?	
What was the largest amount of weight lost, and what method was used for the weight loss?	

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I. Background and Motivation	Responses
Describe in one sentence what failed with previous methods?	
What motivates you to lose weight now?	
What are your personal reasons for wanting to reach your ideal weight?	
II. Goals and Ideals	**Responses**
What is your ideal weight or weight range?	
What are your short-term (3-6 months) weight loss goals?	
What are your long-term (1 year+) weight loss goals?	
What are your non-scale (or measured weight) goals related to health and well-being?	
III. Personal History and Experiences	**Responses**
When did you feel best about your weight?	
Have you experienced any significant life events or changes that impacted your weight?	
Do you have any health conditions or medications that influence your weight?	
Do you have any food sensitivities or allergies?	
Is there anything else you'd like to share about your relationship with food, weight, and your body image?	

IV. Lifestyle and Habits	Responses
Describe your typical daily schedule and activities.	
How many hours of sleep do you get on average?	
How much time do you typically spend sitting or being sedentary each day?	
How many meals do you have/day?	
How many sugary beverages/day?	
How often/week do you eat out at restaurants or order takeout?	
Do you exercise? If yes, how often? (frequency, duration, intensity)	
Do you experience stress or emotional eating? If so, how do you manage these challenges?	
V. Support and Resources	**Responses**
Who will be your biggest supporter in your weight loss journey?	
Are there any specific resources or programs you'd like to explore?	
What are your concerns or hesitations about joining a weight management program, if any?	

LIFESTYLE MEDLY PARTICIPANT AGREEMENT:

By signing below, I acknowledge the following:

(1) I agree to participate in the Lifestyle Medly LLC weight loss program (the "Program"), which may include the use of Tirzepatide or Semaglutide. I have received the Consent for Tirzepatide/Semaglutide for Weight Loss;

(2) I have received the Consent for Telehealth Services;

(3) **I reserve the right to cancel my participation in the Program at any time without penalty, on ten (10) days written notice to support@lifestylemedly.com with a read and delivery receipt;**

(4) I consent to my health information being collected, used, and disclosed as necessary for Program participation, billing, and quality improvement, all in accordance with HIPAA regulations. I have received a copy of the Practice's **Notice of Privacy Practices**, and the **website Privacy Policy and Terms of Use**;

(5) I agree to the Practice's payment requirements as set forth in its **Financial Policy** for the Program. I have received a copy of the Practice's Financial Policy;

(6) I release Lifestyle Medly LLC and its staff from any claims arising from my Program participation unless caused by their negligence or willful misconduct; and

(7) I will receive a copy of this signed agreement for my records.

_____ _____

Printed Name and Signature of Participant Date

