DENVERFATLOSS

DENVER FAT LOSS INTAKE FORM

NAME:_____DATE:_____

ADDRESS:_____CITY:_____STATE:_____

ZIP: _____ CELL #: _____ HOME #:_____

DRIVERS LIC# (NY, KY, AL, IN, CA) _____ BIRTH DATE: _____

WHOM MAY WE THANK FOR REFERRING YOU:_____

EMAIL ADDRESS:_____

MARITAL STATUS: ( ) SINGLE ( ) MARRIED ( ) DIVORCED ( ) WIDOWED ( ) SEPERATED PATIENT

OCCUPATION: _____

EMERGENCY CONTACT: _____

RELATIONSHIP TO PATIENT:_____

CONTACT #: _____ (CELL) HOME

OCCUPATION:_____

EMPLOYER: _____

I am interested in discussing the following programs:

Hormone Replacement Therapy
HGH Peptide Therapy (Ipamorelin or Ibutamoren) Stem Cell Replacement Therapy
MIC / Lipo-B12 / GAC / Vit D etc.
Meal Replacement
IV Therapy
Weight Loss
Sexual Function Therapy
BPC-157 or TB-500 Peptide Therapy Nutritional Coaching

Health History Questionnaire:

Primary Care Doctor (PCP): _____ Phone number: _____

Personal Health History – Check all that apply.

General	Diabetes		High Cholesterol		Unwanted Weight Loss	
Cancer	Personal History of Cancer (non-breast)		Family History of Cancer (non-breast)		Personal or Family history of Breast Cancer	
Cardiovascular	Heart Failure		Heart Attack		Heart Murmur	
	Vascular Disease		Blood Clots		Edema	
	Hypertension		Irregular Heartbeat		Congestive Heart Failure	
Respiratory	Sleep Apnea		Shortness of breath		Asthma / COPD	
	Bronchitis		Pneumonia		Allergies	
Gastrointestinal	Lactose Intolerance		Gall Bladder		Gall Stones	
	Chronic Diarrhea Blood in Urine		Chronic Constipation Kidney/ Bladder History			
Infection	Kidney /Bladder		Liver			
Psychiatric	History of Depression		Personality Disorder			

Do you or any family members have a history of Thyroid Cancer?

Yes/ No_____

Date of your last annual exam / physical? _____

List your prescribed drugs and any over-the-counter drugs, such as vitamins and inhalers.

Drug Name _____ Dosage _____ Frequency _____
Taken for _____

Drug Name _____ Dosage _____ Frequency _____
Taken for _____

Drug Name _____ Dosage _____ Frequency _____
Taken for _____

Allergies: _____ No Known Allergies Or List Allergies and Reaction

_____

_____

Surgeries:

Year _____ Surgery/Reason _____

Year _____ Surgery/Reason _____

HEALTH HABITS AND PERSONAL SAFETY

Exercise: _____ None _____Mild _____ Occasional vigorous exercise _____ Regular vigorous exercise

Describe type of exercise and frequency (resistance training, cardiovascular, number of times per week)

_____

_____

_____

Have you used any hormone (prescribed or otherwise) or any other anabolic steroids in the past?Please be completely truthful with your response, it is critical to diagnose and prescribe correctly.

_____

_

_____

_

Rate your quality of sleep: 1-Worst 10-Best

1 2 3 4 5 6 7 8 9 10

Lifestyle Questionnaire

Alcohol: ____Yes Number of drinks per week: _____ Tobacco:

____Yes _____ Cigarettes ____ Cigars ____

Chewing

Illicit drug use: ____Yes

Explain_____

_____ **Vitals**

Weight _____
Height_____

Previous menstrual cycle start date:
_____

SYMPTOMS OF LOW HORMONE LEVELS

Decreased concentration ____ Yes ____No

Difficulty learning new things ____ Yes ____No

Memory loss ____ Yes ____No

Moodiness ____ Yes ____ No

Depression ____ Yes ____No

Increasing fatigue ____ Yes ____No

Decreasing energy ____ Yes ____No

Daytime sleepiness ____ Yes ____ No

Breast tenderness ____ Yes ____ No

Hot flashes ____ Yes ____ No

Poor sleep habits ____ Yes ____No

Painful intercourse ____ Yes ____ No

I have had my hormone levels checked previously

_____ Yes ____ No I have taken hormone

replacement previously ____ Yes ____ No

If yes, date(s): _____ Type:
_____

____No ____No ____No

ACH Debit Authorization Form

I _____ authorize Denver Fat Loss to charge my credit card for service
PRINT FULL NAME rendered not to exceed the amount shown.

Lab Charge Amount: $ _____USD

Total Charge Amount: $ _____USD

CREDIT CARD

CARD NUMBER _____

CARD CVC _____

EXPIRATION DATE _____

BILLING ADDRESS _____

_____

BILLING ZIP CODE _____

NAME ON CARD _____
(As it appears on card)

_____
SIGNATURE DATE

Denver Fat Loss Peptide Therapy Consent Form

Peptides are small chains of amino acids that can have biological activity and are mostly naturally occurring. The FDA has approved certain peptides for the treatment of certain diseases, but that is outside of our scope of practice. Our peptides are used clinically, FDA approved, and prepared by one our registered compounding pharmacies complying with all state and federal laws. Although peptides can be administered via an array of modalities, our peptides will either be administered subcutaneously with an insulin syringe, orally with a capsule/tablet, or via an intranasal route.

Understanding this, I hereby acknowledge and consent to the following:

_____ 1.) Denver Fat Loss has discussed with me the possibility of integrating peptide therapy into my personal lifestyle routine and potential current treatment regime.

_____ 2.) I understand that the use of peptides is not necessarily approved for my potential medical conditions and that Denver Fat Loss is providing this, following the principles of the practice of medicine and laws regulating compounding pharmacies, as a complement to my current potential treatments.

_____ 3.) As with any other drug, peptide therapies can have side effects, including but not limited to:

- Nausea
- Vomiting
- Fever/headaches
- Injection site reactions (pain, rash, bleeding)
- Allergies
- Night sweats (pre-menopausal)
- Additional side effects not listed

_____ 4.) I understand that alternatives to peptide therapy are:

- Do nothing
- Standard medication use
- Surgery or other therapeutic intervention

_____ 5.) I furthermore understand that Peptide Therapy is being used as part of an integrative treatment approach.

_____ 6.) I agree to follow Denver Fat Loss's guidelines and instructions for my administration of peptide therapy.

_____ 7.) Having read this, I hereby acknowledge that I am voluntarily undergoing peptide therapy and that I hereby relieve Denver Fat Loss of any legal responsibility regarding side effects or complications that may occur, due to receiving peptide therapies.

_____ 8.) I certify that if any concerns or side effects occur, I will promptly notify Denver Fat Loss. I understand that Denver Fat Loss is not responsible for any manufacturing issues related to these peptides, such as sterility and potency, which are the sole responsibility of the compounding pharmacy preparing them.

_____ 9.) I certify that I understand the information above and that I have no questions on This. This program and all treatments associated with, are non refundable.

Patients Name Printed_____

Today's Date _____

Patient Signature_____

Notes: