YELLOWSTONE NATUROPATHIC CLINIC
720 N 30th St Billings, MT 59101 406-259-5096 Fax: 406-545-0044

hCG SCREENING FORM

Name _____ Age ___ Birth date _____ Blood type _____

Address _____ City _____ State ___ Zip _____

Phone (home) _____ (work) _____ Daytime or eve? ____

Last physician or healthcare practitioner seen? _____ When? _____

When was your last blood test?_____ Last Mammogram? _____ PAP?_____

Your Current Health Problems

List in order of importance other health problems troubling you:

1)_____ Length of time_____

2)_____ Length of time_____

3)_____ Length of time_____

Have you participated in other weight loss programs? What type?_____
[] Yes [] No

Your Health History

Previous surgeries and hospitalizations (including dates) _____
_____
_____

Please indicate which of the following are current or past medical problems (include the year).

	now	past		now	past		now	past
Allergies			Anemia			Asthma		
Cancer			Canker sores			HIV		
Chronic infections			Crohn's disease or Ulcerative colitis			Diabetes		
Ear infections			Eczema			Enlarged prostate		
Epilepsy			Thyroid problems			Headaches		
Heartburn			Heart disease			Heart palpitations		
Hemorrhoids			Hepatitis			Stomach ulcer		
Eating disorder			High Blood pressure			Irritable Bowel Syndrome		
Mononucleosis			Numbness			Osteoporosis		
Pancreatitis			Polyps			Osteoarthritis		
Other:								

Continued on Back →

Are you allergic to any drugs, herbs, foods, animals or other? _____ Which one(s)? _____

_____

Family History

Please list ages, health problems and if deceased, the cause of death (only include blood relatives):

	Living(L) or Deceased(D)	Health Problems	Age	Cause of death
Mother				
Father				
Brothers				
Sisters				
Grandparents				
Mother's mom				
Mother's dad				
Father's mom				
Father's dad				

Diet

Are you following any specific diet or dietary restrictions? _____

Do you consume caffeine? *[] No [] Yes* Do you consume pop? *[] No [] Yes*

How much water do you drink in a typical day (ounces /glasses/ cups)?_____

What do you typically eat for Lunch?_____

_____

Exercise

Activity	Days per week	Minutes per session	Year and month started

Have you ever had challenges with dependency?

[] Alcohol [] Nicotine [] Rx Drugs [] Recreational drugs

Do you smoke? *[] No [] Yes* Packs per day:_____ Number of years: _____

Do you drink alcohol? *[] No [] Yes* Drinks per day:_____ Drinks per week:_____

Stress

On a scale of 1 – 10 (1 = none, 10 = extreme) please describe psychological/emotional stress levels:

Occupational:_____ Personal:_____

This visit is solely for the purpose of screening for the above procedure only. *It is limited in scope and not a replacement for a personal physician.* A report will be sent to your personal physician <u>if requested</u> (name) _____

Patient Signature _____ Date _____

Physician Signature _____ Date _____

YELLOWSTONE NATUROPATHIC CLINIC
720 N 30th St Billings, MT 59101 406-259-5096 Fax: 406-545-0044

INFORMED CONSENT FOR hCG WEIGHT LOSS THERAPY

Patient Name: _____

PHYSICIAN SIGNATURE: _____

1. This document is a binding agreement between Yellowstone Naturopathic Clinic (YNC) and the individual patient whose name and signature appear below. By signing this agreement, the individual acknowledges the below articles, agrees to them and has given informed consent to YNC to perform this procedure. You have the right to be informed about the procedure, any feasible alternatives and risks. You also have the right to a more detailed explanation and to have your questions answered by the physician prior to treatment.
2. hCG therapy may involve insertion of needles into your skin and the injection of standardized, FDA approved prescriptive medicines (Human Chorionic Gonadotropin). The exact solution and site of injection for treatment, as well as their recommended sequence of treatments, will be detailed to you when the treatments are prescribed.
3. Alternatives to hCG therapy include other weight loss programs, exercise, drug therapy, lap band surgery, and taking no action.
4. The side effects of hCG use are uncommon. The hCG side effects may include headaches, irritability, restlessness, slight water retention, tenderness of breast tissue, swelling of the injection site, and depression. The development of ovarian hyperstimulation syndrome is a rare side effect that can develop in females. This condition requires immediate medical treatment and is accompanied by the following symptoms: tremendous pain in the region of the pelvis, the swelling of feet, legs and hands, abdominal pain, abdominal swelling, difficulty breathing, diarrhea, vomiting, nausea, a diminishing of urination and weight gain. If a user of hCG products notes any side effects it is recommended that he or she cease using the products and seek out the assistance of a physician immediately.
5. You have the right to either consent or refuse a proposed treatment at any time prior to its performance. In addition, you may revoke your consent at any time during the treatment at which point the treatment will be terminated.
6. If you are to drop out of the program for some reason, your money will not be refunded as staff has set aside time blocks for your utilization and success in this program.
7. Your signature below means:
   a. You have read and understand the information provided on this form and agree to the above.
   b. You received all the information and explanation you desire concerning the procedure.
   c. You authorize and consent to the performance of the procedure.

This consent covers a series of treatments/procedures for this purpose only and is limited in scope.
It is not a replacement for a personal physician.
A report will be sent to your personal physician <u>if requested</u> (name) _____

Patient / Representative: _____
Print Name Signature

Date: _____ If signed by Representative, indicate relationship: _____

Witness: _____ Date: _____