PLEASE NOTE: None of the following information is stored digitally

Locations

Arcadia	Glendale	Tempe
3801 N. 24th Street	6008 W Bell Rd	3141 S. McClintock, Dr.
Phoenix, AZ 85016	Glendale, AZ 85308	Tempe, AZ 85282
602.441.3305	602-374-3374	480.968.5673

**Offer valid for new patients only. Not valid with any other offer.*

New Patient Form: *(Internet)*

First Name: Last Name:

Address: City: State: Zip:

Date of Birth: Age: Sex Male: Female: Phone:

Email:

Primary Care Physician:

Emergency Contact: Emergency Contact Phone:

Check if you do not wish to be contacted via phone or email for marketing purposes

Have you ever been a Valley Medical Weight loss patient?: Yes No

Have You Ever Had Or Currently Have Any Of The Following:

	Yes	No	Not Sure		Yes	No	Not Sure
Heart Trouble:				Heart Palpitations:			
High Blood Pressure:				Thyroid Issues:			
Low Blood Pressure:				Bowel Issues/Constipation:			
Diabetes:				Glaucoma:			
High Cholesterol:				Leg Cramps:			
Anxiety/Depression:				Dizziness:			
Fatigue:				Epilepsy/Seizures:			
Allergies:				Frequent Headaches:			
Allergic to Lidocaine:				Irregular Menstruation:			
Gallbladder Issues:				Fibroids/Ovarian Cysts:			
Cancer:				Female Organ Problems:			
Shortness of Breath:				Kidney Trouble:			
Difficulty Sleeping:				Do you Smoke:			
Phenylketonuria (PKU):				Pregnant or Breast Feeding:			
Hep B:				History of Substance Abuse:			
Hep C:				HIV:			

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Patient Name

First Name: Last Name:

What is your GOAL WEIGHT? lbs. Your statement of present health is: Excellent Good Fair/Poor

Have you ever been on a weight loss program: Yes No If yes, please explain:

Do you exercise? Yes No How often? 4-5x a week 2-3x a week 1x a week Rarely Never:

	Yes	No	
Do you drink coffee:			
Do you drink soda:			
Do you drink energy drinks:			
Do you drink alcohol:			
Do you eat 3 meals a day:			
Do you eat out:			If yes, how many times per week?
Do you crave sweets:			
Do you crave carbs:			
Do you crave salt:			
Do you take any medications:			If yes, list all your medications *(If your list is to long to fit, please bring in a list of your medications)*
Do you take any supplements:			If yes, list all your supplements *(If your list is to long to fit, please bring in a list of your supplements)*

Complete, print & present this form *with your ID at time of visit.*

How Did You Hear About Us?

Internet Facebook Radio/Pandora TV Groupon/Living Social Yelp Billboard Mailer/Inside Coup

Post Card Other REFERRED by Friend/Family*

** We offer FREE WEIGHT loss for friends and family referrals. Ask a member of our staff about our referral program.*

Patient Consent
The above information is a true representation of my current health status. I have read and understand the above and hereby agree to treatment administered to me, including medications for weight loss. I, the undersigned, having been informed by Valley Medical Weight Loss and/or Valley Medical Weight Control of the hazards and possible consequences involved in treatment by medications, supplements injections, and nonetheless consent to such treatment and agree to hold Valley Medical Weight Loss and/or Valley Medical Weight Control and any of it's affiliates free and harmless of any claims, demands or suits for damage from any injury or complications whatsoever, save negligence, that may result in such treatment.

Notice: *All patients may receive medications dispensed by physician (or receive written prescription to take to a pharmacy of their choice for a fee.)*

IF YOU SUSPECT YOU ARE PREGNANT DISCONTINUE ALL MEDICATIONS, SUPPLEMENTS OR INJECTIONS. PREGNANT OR NURSING MOTHERS SHOULD NOT BE TAKING THIS MEDICATION.

Sign Date

If patient is under the age of 18, a parent or guardian must sign above.

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