Comprehensive Weight Management, A Nursing Corp.
72 S. Ocean Ave., Cayucos, CA 93430

Name_____ DOB_____ Date_____

Address _____ Age_____ Male/Female

City _____State_____Zip_____

Best Phone_____ Alt 1_____ Alt 2_____

Occupation_____ How did you hear about my practice?_____

Primary Physician_____ Other Providers_____

Consent for Treatment

I, _____, agree to be treated by nurse practitioners Carol Rowsemitt, PhD, RN, FNP-BC, or Lori Wenz, RN, AGNP-C, BC-ADM under the supervision of Shebani Sethi Dalai**,** MD.

I UNDERSTAND THAT:

- **The nurse practitioners at CWM do not provide primary care. I understand that this practice is restricted to issues related to weight management and thyroid disorders. I agree to maintain a primary care provider for other aspects of my health care.**
- **Many of the prescribed treatments for both weight management and thyroid disorders are not considered "standard of care" that is, the treatments used here are somewhat different than those typically accepted by the majority of the medical community. Some medications are used for treatments not authorized by the FDA.** I understand that these issues will be explained to me and discussed with me so that I will have the benefit of comprehensive informed consent.
- **Current research may be limited on some new therapies.** Treatment options will be discussed in regard to potential risks and benefits. I have the right to decline any treatment at any time.
- **Some risks/outcomes may be unknown and I agree to assume these risks.**
- Vitamins and supplements advised during my visits as well as laboratory tests requested are necessary to help me remain healthy while on my program.

Signed:_____ Date:_____

Print Name: _____

Cancellation/Rescheduling Charges

We do not double-book appointments. Therefore, the following charges will be applied:

Cancellation with less than 24-hr notice	**$35**
Rescheduling with less than 24-hr notice	**$35**
No-Show	**$50**
No-Show first visit	**$100**

By signing this, I acknowledge that I have read the above, and agree to comply with this policy.

Signed:_____

Patient Name **Medical History** (revised 8/19) Date

Disease/Problem	Current	Past	Disease/Problem	Current	Past	Comments on any Problems
Migraines			Arthritis (Osteoarthritis)			
Other Headaches			Asthma			
Frequently feel hot			Bladder/kidney problems			
Frequently feel cold			Blood clot - leg			
Frequently have cold hands or feet			Blood clot - lung			
More tired than I deserve			Blood transfusion			
Glaucoma			Breast lump (benign)			
Other vision problems			Cancers (Put type in comments)			
Seizures			Cataracts			
Chest pain at rest			Chicken pox			
Chest pain on exertion			Colon polyp			
Short of breath at rest			Diverticulitis			
Short of breath on exertion			Diabetes Type 2-adult onset			
High blood pressure			Diabetes (gestational)			
Heart palpitations (racing or irregular)			Emphysema			
Chronic cough			Heart Disease-includes attack, angina			
Swelling, for example, hands/feet			High cholesterol			
Heart problem			Stroke			
Sleep apnea (stop breathing in sleep)			Low thyroid			
For weight loss patients only:			High Thyroid			
Check all that describe your appetite lately			Chronic Fatigue Syndrome			
Large appetite			Fibromyalgia			
Normal appetite			Overweight/obese			
Small appetite			Underweight			
Never feel full			Alcoholism			
Always hungry			Drugs problems			
I don't crave any kinds of foods			Autoimmune diseases:			
I crave:			Multiple sclerosis			
No cravings, but snack a lot			Rheumatoid arthritis			
Anorexia			Vitiligo			
Bulimia			Celiac Disease			
Often constipated			Crohn's Disease			
Often diarrhea			Ulcerative colitis			
Heartburn			Graves' disease			
Get up to urinate at least 2 times at night			Lupus			
Kidney stones			Hashimoto's desease			
Women only:			Psoriasis			
Last menstrual period			Diabetes Type 1-childhood onset			
Method of birth control			Hair Thinning			
Trouble falling asleep			Dry Skin			
Trouble staying asleep			In the past 2 years, have you had:			
Depression			eye exam?			
Anxiety			dentistry?			
Joint pain (where?)			general physical exam?			
Muscle pain (where?)			mammogram? (women only)			
Numbness or tingling (where?)			Have you had a screening			
Tattoos			colonoscopy (if over 50)?			
Allergies			**Comments:**			
Anemia						

Patient Name ____________________

Surgeries

Surgeries and Procedures	X for Yes	Year	Comments
Abdominal			
Appendectomy			
Back surgery			
Biopsy (location)			
Breast biopsy			Circle: R L Both
Breast surgery			Circle: R L Both
Cataract			
Colonoscopy			
Coronary Artery Bypass			
Coronary Stent			
Endoscopy (Stomach)			
Gallbladder removal			
Gastric bypass			type:
Heart surgery (other)			
Hip surgery			Circle: R L Both
Hysterectomy			
total, includes ovaries			
partial, ovaries remain			
Knee surgery			Circle: R L Both
LEEP (cervix surgery)			
Neck surgery			
Tubal Ligation			
Ovary removal			Circle: R L Both
Vasectomy			
Sigmoidoscopy			
Sinus surgery			
Other: please list			

Medications/Supplements **Date** ___________

(Print here or attach list)

Name	Dosage	Times/day	Purpose

Allergies to Medications:

Response:

No Medication Allergies ☐

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Name _____ **Family History** Date_____

Disease/Problem	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative	Comments
No history known										
Weight problems										
Anorexia										
Bulimia										
Diabetes (adult onset)										
Heart Disease										
Heart Attack										
Angina (chest pain)										
High cholesterol										
Stroke										
Cancers										
Include type in comments										
Low thyroid										
High Thyroid										
Depression										
Suicide										
Kidney Stones										
Alcoholism										
Drugs problems										
Autoimmune diseases:										
Multiple sclerosis										
Rheumatoid arthritis										
Vitiligo										
Celiac Disease										
Crohn's Disease										
Ulcerative colitis										
Graves' disease										
Lupus										
Hashimoto's desease										
Psoriasis										
Diabetes (childhood onset)										
Other										
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