

Name _____ DOB _____ Date _____
Address _____ Age _____ Male/Female/Other/Decline
City _____ State _____ Zip _____
Best Phone: _____ Alternate phone: _____ Email _____
Occupation _____ How did you hear about our practice? _____
Primary Physician _____ Other Providers _____
Best way to get in touch with you: _____

Consent for Treatment

I, _____, agree to be treated by Carol Rowsemitt, RN, FNP-BC, family nurse practitioner.

I UNDERSTAND THAT:

- **Carol does not provide primary care and that her 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 regarding potential risks and benefits, particularly with thyroid treatment. 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.
- Comprehensive Weight Management is authorized by me to release to and obtain from my primary care provider for continuity of care. Please mark:

All of my medical records or only disclose and/or release the following specific information:

Cancellation/Rescheduling Charges

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

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

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

Signed: _____

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-inc attack, angine			
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 disease			
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						

Name _____

Family History

Disease/Problem	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Offspring	Other Relative	Comments
No history known											
Weight problems											
Anorexia											
Bulimia											
Diabetes (adult onset)											
Heart Disease											
Heart Attack											
Angina (chest pain)											
High cholesterol											
High blood pressure											
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 disease											
Psoriasis											
Diabetes (childhood onset)											
Other											
											© C. Rowsemitt 2022