ALPHA WEIGHT LOSS @ ALPHA HEALTH CENTER

Name: _____ Date: _____

Address: _____ City: _____ Zip: _____

Phone: (H) _____ (C)_____ (W)_____

Age: _____ Date of Birth: _____ Occupation: _____

Status: Single / Separated / Married/ Divorced / Widowed

Employer: _____ E-mail: _____

Referred by: _____

Please mark the box if you have had any of the following:

- ☐ Headache
- ☐ Neck pain
- ☐ Back pain
- ☐ Knee pain
- ☐ Hip pain
- ☐ Fatigue
- ☐ Difficulty getting to sleep
- ☐ Difficulty staying asleep
- ☐ Heart Disease
- ☐ Diabetes
- ☐ High stress
- ☐ Over heating
- ☐ Cold hands and feet
- ☐ Low sex drive
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas after meal
- ☐ Frequent Urination
- ☐ Sugar Cravings
- ☐ Thyroid Problems
- ☐ Adrenal Problems
- ☐ Irritable if meals are missed
- ☐ Fatigue after meals
- ☐ Fibromyalgia
- ☐ Depression
- ☐ Mental fatigue
- ☐ Menopause
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Ovary Problems
- ☐ Liver Problems

Exercise (*circle one*): Light / Moderate / Heavy / None
Frequency: _____ per week

Please list any medications you are currently taking: _____

_____

Current Weight: _____ Goal Weight: _____

Desired Completion Date: _____

PATIENT QUALITY OF LIFE SURVEY

Alpha Health Center
Dr. Jeff W. Lissenden, DC
Chiropractic Physician

Name:_____ ***Date:***_____

Please take several minutes to answer these questions so that we can help you improve your health.
(Please circle as many that apply)

1. **How have you taken care of your health in the past?**
   a. **Medications**
   b. **Emergency Room**
   c. **Routine Medical**
   d. **Exercise**
   e. **Nutrition/Diet**
   f. **Holistic Care**
   g. **Vitamins**
   h. **Chiropractic**
   i. **Other (please specify):**_____

2. **How did the previous method(s) work out for you?**
   a. **Bad results**
   b. **Some results**
   c. **Great results**
   d. **Nothing changed**
   e. **Did not get worse**
   f. **Did not work very long**
   g. **Still trying**
   h. **Confused**

3. **How have others been affected by your health condition:**
   a. **No one has been affected**
   b. **Haven't noticed any problem**
   c. **They tell me to do something**
   d. **People avoid me**

4. **What are you afraid this might affect?**
   a. **Job**
   b. **Kids**
   c. **Future ability**
   d. **Marriage**
   e. **Self-esteem**
   f. **Sleep**
   g. **Time**
   h. **Finances**
   i. **Freedom**

5. **Are there health conditions you are afraid this might turn into?**
   a. **Family Health Problems**
   b. **Heart Disease**
   c. **Cancer**
   d. **Diabetes**
   e. **Arthritis**
   f. **Fibromyalgia**
   g. **Depression**
   h. **Chronic Fatigue**
   i. **Need Surgery**

6. **How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:**

   _____
   _____
   _____
   _____

7. **What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:**

   _____
   _____
   _____

8. **What are you most concerned with regarding your problem:**

   _____
   _____

9. **Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.**

   _____
   _____
   _____
   _____

10. **What would be different/better without this problem? Please be specific.**

    _____
    _____

11. **What do you desire most to get from working with us?**

    _____

12. **What would that mean to you?**

    _____
    _____

PATIENT QUALITY OF LIFE SURVEY

Alpha Weight Loss, LLC
1320 SE Maynard Rd. Suite 102
Cary, NC 27511

General Consent Form to the Use and Disclosure of **Protected Health Information**

I understand that Alpha Weight Loss, LLC creates and maintains medical and related records that include personal healthcare information including my health records, symptoms, demographic information, diagnosis, examination and test results, treatment, and any plans for the future care or treatment. This is my "**protected health information**" **(PHI)**.

I understand and consent to the use and disclosure of my health information by Alpha Weight Loss, LLC for the following purposes:

1. **My treatment:** This includes the provision, coordination, or supervision of my healthcare and related services, including the coordination or management of my care and consultation between healthcare professionals related to my treatment, or my referral to another healthcare professional.
2. **Payment for healthcare services provided to me:** This includes actions undertaken by a health plan to decide coverage or the provision of benefits to me, by my provider or a health plan to obtain or provide compensation for my care, or otherwise related to me.
3. **My provider's internal operations:** This includes quality assessment and improvement activities; reviewing provider performance and training; activities relating to health insurance and benefits; conducting or arranging for medical review, legal services, and audits; business planning and development; and business management and general administrative activities including customer service, resolution of internal grievances, due diligence, and creating de-identified healthcare information.

I understand and agree that:

1. I have the right to review Alpha Weight Loss, LLC's Notice of Privacy Practices for Protected Health Information, which provides a much more detailed description of information uses and disclosures, prior to signing this consent
2. Alpha Weight Loss, LLC may change or modify its Notice of Privacy Practices for Protected Health Information at any time and I have the right to obtain a revised notice of privacy practices by written request to be sent in the mail or by asking for one at the time of my next appointment.
3. I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. I understand and agree that my provider is not required to agree to any restrictions that I may request, but if my provider agrees, will be bound by that restriction.
4. I have the right to revoke the consent by notifying my provider in writing that I revoke this consent unless my provider has used or disclosed my health information in reliance on this consent.
5. My provider has the right to disclose relevant health information to my family member, other relative, close personal friend or anyone identified by me.

Who can receive phone messages from us regarding your PHI: _____

Who can cancel or change appointments for you? _____

Printed Name	Authorized Provider Representative
Signature	Date
Date	