

# OPTIONS DIET CLINIC

5407 HWY 5 North, Suite 17

Bryant, AR 72022

501 - 847 - 4735

## Registration Form

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

DOB: \_\_\_ / \_\_\_ / \_\_\_

\_\_\_\_\_

Sex: M / F

City

State

Zip

Home Phone: (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

Work Phone: (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

What do you weigh now? \_\_\_\_\_

What is your goal weight? \_\_\_\_\_

How long do you expect it will take you to reach your goal weight? \_\_\_\_\_

What is your best adult weight ever? \_\_\_\_\_

How long ago did you weigh this? \_\_\_\_\_

Have you tried other diet programs? Yes / No

Were you successful? Yes / No

Comments: \_\_\_\_\_

\_\_\_\_\_

### Questions in this Section are OPTIONAL

Cell: (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_ @ \_\_\_\_\_

Marital Status: S / M / D / W

Spouse, Significant Other, or Next of Kin

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_

Physician: \_\_\_\_\_

Phone: (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

**We Look Forward to Working With You!**

# OPTIONS DIET CLINIC

## General Health Questions

(YES/NO)

- \_\_\_ 1 Are you a man over 45 years old?
- \_\_\_ 2 Are you a woman over the age of 55?
- \_\_\_ 3 Are you a woman less than 55 years old and past menopause but not taking estrogen?
- \_\_\_ 4 Are you breast feeding?
- \_\_\_ 5 Have you had weight loss surgery? If so, when? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- \_\_\_ 6 Has any male family member died of a heart attack before age 55?
- \_\_\_ 7 Has any female family member died of a heart attack before age 65?
- \_\_\_ 8 Do you smoke cigarettes?
- \_\_\_ 9 Has a doctor ever told you that you have high blood pressure?
- \_\_\_ 10 Has your blood pressure been greater than 140 / 90 on more than one occasion?
- \_\_\_ 11 Do you take high blood pressure medicine or fluid pills?
- \_\_\_ 12 Has your doctor ever told you that you have high cholesterol?
- \_\_\_ 13 Do you know if your total cholesterol is greater than 200?
- \_\_\_ 14 Do you know if your HDL cholesterol is less than 35?
- \_\_\_ 15 Are you diabetic?
- \_\_\_ 16 Are you at least twenty pounds overweight?

**Options Diet Clinic**

\_\_\_ **Do you take prescription medications?** (if yes, then list)

Drug Name	Dosage
_____	_____
_____	_____
_____	_____
_____	_____

\_\_\_ **Do you have any allergies?** (if yes, then list)

Allergy	What type reaction? (hives, can't breathe, etc)
_____	_____
_____	_____

\_\_\_ **Have you had surgery?** (if yes, then list)

Type of Surgery	Date
_____	_____
_____	_____

**Have you had?** (yes/no)

- \_\_\_ heart attack                      \_\_\_ heart surgery                      \_\_\_ Cardiac cath
- \_\_\_ angioplasty (PTCA)              \_\_\_ heart valve disease              \_\_\_ heart failure
- \_\_\_ heart transplant                  \_\_\_ congenital heart disease
- \_\_\_ pacemaker / implantable cardiac defibrillator / Cardiac rhythm disturbance
- \_\_\_ seizure disorder                  \_\_\_ Bipolar disorder                  \_\_\_ diabetic requiring insulin
- \_\_\_ serious accident                  \_\_\_ broken bones

**Have you experienced any of these?**

- \_\_\_ Chest discomfort with exertion      \_\_\_ unexplainable breathlessness
- \_\_\_ dizziness, fainting, blackouts      \_\_\_ musculoskeletal problems
- \_\_\_ concerns for your safety during exercise

Please initial here indicating all information provided is accurate to the best of your knowledge:

**INITIALS** \_\_\_\_\_

**Options Diet Clinic**

**5407 Hwy 5 N. Ste.17, Bryant, AR 72022**

**501-847-4735**

I understand that while I am taking prescription diet medications there are potentially dangerous interactions such as, hypertension, stroke, or heart attack if taken with:

Other prescription diet medications

Over the counter stimulants for weight loss including herbal combinations

Energy drinks or tablets

Stimulant medications prescribed for Attention Deficit Disorders (such as but not limited to, Adderall, Concerta, Vyvanse, Ritalin, etc.)

Decongestants for sinus problems, either by prescription or over the counter

(e.g. Sudafed/pseudoephedrine combinations)

***I agree not to take the diet medication prescribed by Dr. Caruthers for this weight loss program in combination with any other stimulant diet medication or any other medications described here.***

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Print)

Signature: \_\_\_\_\_