



Name: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

DOB: \_\_\_\_\_ Current Age: \_\_\_\_\_ Sex: M F

Email: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contacts:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about us?

Internet Yard Sign Radio Sign Employer Referred By:
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REQUIRED LAB TESTS

Patients receiving prescription appetite suppressants are required to have the following labs completed prior to receiving their second prescription:

- CMP - Comprehensive Metabolic Panel is a panel of 14 blood tests which serves as an initial broad medical screening tool. The CMP provides a rough check of kidney function, liver function, diabetic and parathyroid status, and electrolyte and fluid balance, but this type of screening has its limitations.
TSH - Measures the amount of Thyroid Stimulating Hormone in the blood.
Lipid Panel - A blood test that measures lipids-fats and fatty substances used as a source of energy by your body. Lipids include cholesterol, triglycerides, high-density lipoprotein (HDL), and low-density lipoprotein (LDL).

If you have had these 3 specific lab tests done within the past 90 days, you are welcome to submit a copy for our records. Otherwise, blood can be drawn by (drop box) on or before your first refill date for a \$45 fee.

Your new prescription may be obtained the same day blood is drawn if mandatory 28-day requirement since the date of your last prescription has been met.

I have read and understood all above information and agree to these statements.

Patient's/Guardian's Name Date

HIPAA

I have received/reviewed a copy of the HIPAA privacy notice found at www.beehealthyclinics.com and understand that I may request to have a full signed copy added to my electronic client portal at any time.

Patient's/Guardian's Name Date

## DISCLOSURE AND CONSENT FORM

TO THE PATIENT (AND OTHERS LEGALLY RESPONSIBLE FOR THE PATIENT): You have the right to be informed about your condition and how integrative and alternative medicine may be applied in a treatment plan. This disclosure is intended to provide an opportunity for you to make an informed decision so that you may give or withhold your consent to treatment that may be considered unconventional by physicians trained only in the United States: NOTICE: Refusal to consent to the integrative and alternative procedure(s) shall not affect your right to future care or treatment.

I voluntarily request that Dr. Kenneth Grotz and other Bee Healthy Evans, LLC health care personnel as he may deem necessary, treat my condition (or the condition of the person for whom I am responsible) as described below.

I understand that each of these integrative and alternative treatments are available to me (or the person for whom I am responsible). I voluntarily consent and authorize the following: Administration of homeopathic remedies, herbal and nutritional therapies, off label use of pharmaceuticals, injectable vitamins, and amino acids.

I understand that no warranty or guarantee has been made regarding results of treatment. I realize that there may be risks and hazards related to the planned integrative treatment, including worsening of present symptoms, development of new symptoms (especially detox reactions) and undesirable interactions between various treatments, both conventional and alternative.

I have been given an opportunity to ask questions about the treatment of this health condition using conventional, integrative, and alternative methods. I have had an opportunity to discuss the possible risks and hazards of treatment and non-treatment. I believe that I have sufficient information to sign this informed consent. I certify this form has been fully explained to me, that I have read it (or have had it read to me), that the blank spaces have been filled in, and that I understand its contents.

I also certify that Dr. Kenneth Grotz and other Bee Healthy Evans, LLC health care personnel have provided this Disclosure and Consent Form to me, fully explained the diagnostic and treatment options available, and have made no guarantees to me as to the success of this treatment. I acknowledge that Dr. Kenneth Grotz and other Bee Healthy Evans, LLC health care personnel have informed me that they function only as educators and consultants not as the primary care physician for any patient. I have assured him that I have a primary physician and do not/will not rely on Dr. Kenneth Grotz and other Bee Healthy Evans, LLC or other affiliated health care personnel for that role.

**SIGNATURE OF THE PATIENT OR OTHER LEGALLY RESPONSIBLE PERSON REQUIRED BELOW:**

\_\_\_\_\_  
Patient's/Guardian's Signature

\_\_\_\_\_  
Date

**CLINIC USE ONLY:**

**PHYSICIAN DECLARATION**

I have explained the contents of this document to the patient and have answered all the patient's related questions and to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of appetite suppressants, as well as the risks of continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving appetite suppressants in the manner indicated above.

\_\_\_\_\_  
Physician/NP/PA Signature

\_\_\_\_\_  
Date

## **PATIENT/FAMILY MEDICAL HISTORY**

**Present Health Status:**

1. Are you in good health at the present time, to the best of your knowledge? YES      NO  
 if "NO," explain: \_\_\_\_\_

2. Are you under a doctor's care at the present time? YES      NO  
 If "YES," explain: \_\_\_\_\_  
 \_\_\_\_\_

3. Name of your Primary Care Physician  
 \_\_\_\_\_

4. Are you taking any medications at the present time? YES      NO  
 List all prescribed medications and over the counter medications.

**Please check box to note if medication is prescribed (RX) or Over the Counter (OTC).**

Name of the Medication	RX	OTC	Dosage	Schedule

5. Any allergies to sulfa/sulfur type medications or *any other medications*? YES      NO  
 If "YES," please list below: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Do you have any of the following?:**

- History of High Blood Pressure? YES      NO
- History of Diabetes? YES      NO  
 Type I \_\_\_\_\_ Type II \_\_\_\_\_ At what age? \_\_\_\_\_
- History of Heart Attack or chest pain or other heart condition? YES      NO

If "YES," explain: \_\_\_\_\_

- History of swelling feet? YES      NO
- History of frequent headaches or migraines? YES      NO
- History of constipation (Difficulty in bowel movements)? YES      NO
- History of Glaucoma? YES      NO
- History of Sleep Apnea? YES      NO
- Do you use a C-PAP? YES      NO
- Any surgery/surgeries? YES      NO

Specify type of surgery and date:

- 1.
- 2.
- 3.

- Do you have any other medical problems or concerns? YES      NO

If "YES, explain: \_\_\_\_\_

**Medical History Continued (Check all that apply)**

<input type="checkbox"/> Gallbladder disease	<input type="checkbox"/> Heart valve disorder	<input type="checkbox"/> Drug abuse	<input type="checkbox"/> Kidney disorder
<input type="checkbox"/> Liver disease	<input type="checkbox"/> Depression/anxiety	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Anemia
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Psychiatric illness	<input type="checkbox"/> Lung disease	<input type="checkbox"/> Bleeding disorder
<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Alcohol abuse	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Thyroid disorder
<input type="checkbox"/> Gout	<input type="checkbox"/> Cancer	<input type="checkbox"/> Other: _____	

**Family History (Please complete this section in its entirety)**

	Age	General Health	Disease(s)	Overweight	Cause of Death
Father					
Mother					
Brother(s)					
Sister(s)					

Has any blood relative ever had any of the following?:

High Blood Pressure: YES NO Who: \_\_\_\_\_ Age: \_\_\_\_\_

Kidney Disease: YES NO Who: \_\_\_\_\_ Age: \_\_\_\_\_

Heart attack/Stents/Bypass/Stroke: YES NO Who: \_\_\_\_\_ Age: \_\_\_\_\_

**This is a complete and full disclosure and summary of my medical history.**

\_\_\_\_\_  
Patient's/Guardian's Name

\_\_\_\_\_  
Date

**NUTRITION EVALUATION**

What brings you in today? Lose Weight \_\_\_\_\_ Gain Energy \_\_\_\_\_ Improve Overall Wellness \_\_\_\_\_

If wanting to lose weight, do you have a goal in mind? Pounds \_\_\_\_\_ Time Frame \_\_\_\_\_

How long have you struggled with weight loss? \_\_\_\_\_

Please list any diets, vitamins, supplements, or weight loss medications you are currently using or have tried in the past:

Previous Program	Date	Results	Still Using?

How much water do you drink per day? \_\_\_\_\_

Do you drink coffee, soda, or tea? YES NO How much daily? \_\_\_\_\_

Please describe your eating habits. How many times per day do you eat and what types of foods?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you exercise? YES NO What Type? \_\_\_\_\_ How often? \_\_\_\_\_