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:
____ Social Media ____ Billboard ____ TV ____ Mail ____ Event ______________________

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. James Allen Hicks and other Bee Healthy Irmo, 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. James Allen Hicks and other Bee Healthy Irmo, 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. James Allen Hicks and other Bee Healthy Irmo, 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. James Allen Hicks and other Bee Healthy Irmo, LLC 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)

☐	Gallbladder disease	☐	Heart valve disorder	☐	Drug abuse	☐	Kidney disorder
☐	Liver disease	☐	Depression/anxiety	☐	Heart disease	☐	Anemia
☐	Ulcers	☐	Psychiatric illness	☐	Lung disease	☐	Bleeding disorder
☐	Eating disorder	☐	Alcohol abuse	☐	Arthritis	☐	Thyroid disorder
☐	Gout	☐	Cancer	☐	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?______________________