



# New Client Questionnaire

PATIENT INFORMATION	Last Name	First	MI	Female ( ) Male ( )	Birth Date	Age
	Address	Apt#	City	State	Zip	
	Home Phone	Cell Phone		Primary Care Physician		
	E-Mail			Marital Status		
	Occupation	Employer		Work Number		
	Emergency Contact	Relationship			Phone	

HELPFUL INFO	How Did You Hear About Vital Solutions MD?			
	Internet	Family Member	Friend	Magazine Advertising
	Your Doctor	Yellow Pages	Flyer at Store	Radio
	TV Segment	Received Ad in Mail	Google Search	Other

FITNESS HISTORY	Number of hours worked per week	<i>Under 20</i>	<i>20-40</i>	<i>41-60</i>	<i>Over 60</i>	
	More than 25% of the time at your job is spent	<i>Sitting at desk</i>	<i>Lifting loads</i>	<i>Standing</i>	<i>Walking</i>	<i>Driving</i>
	Are you currently exercising?	Yes	No	If yes, please describe what and how long		
	What is your current weight?	When did you feel most satisfied with your weight/fitness level?				
	What is your desired weight?	What was your weight when you felt your best?				
	Do you enjoy Exercise?	Do you find time to exercise when you are busy?				

LIFESTYLE	Do you sleep 7 to 8 hours nightly?	Do you receive regular medical care?
	Do you take supplements? Please List	

<b>NUTRITION</b>	How many diets have you been on in the last 3 years? Describe the diets you've been on.			
	Describe the results you had with any of these diets.		How much weight did you lose?	
			Did you gain any of it back?	
	Did you experience and problems while dieting?      Usually                      Sometimes                      Rarely			
	Do you regularly eat breakfast?		Are you ever hungry again within 1 – 2 hours of eating?	
	Do you ever eat when you are not hungry? Reasons?		How much water do you drink in a typical day?	

<b>TYPICAL DAILY DIET</b>	How many times per day do you eat on average (including snacks)?	
	What is your typical daily diet?	Breakfast?
	Snacks?	Lunch?
	Snack Times?	Dinner?
	How many times per week do you eat at restaurants (eat in or take out)?	Do you avoid refined sugars? (Sweets, candies, cookies, cakes etc
	Please rate the level of your stress: Low    1    2    3    4    5                      High	Do you eat or drink to the point of discomfort? Do you eat or drink when you are bored or stressed?
	What do you do to relieve stress?	
	Do you rely on stimulants (alcohol, cigarettes) to reduce your stress level?	

<b>TYPICAL DAILY DIET</b>	Do you drink alcohol? If yes, how many days per week? How many drinks per occasion?	Do you drink coffee, tea or caffeinated soda? How much daily?
	Which best describes your sleeping patterns? Excellent                      Average                      Poor	On average, how many hours do you sleep at night?
	Do you wake often at night?	Do you find it difficult to fall asleep at night?
	Do you awake feeling rested?	Which describes your energy levels throughout the day?
	Have you ever had you're metabolic rate measured?	Morning:            High    Medium            Low Afternoon:        High    Medium            Low Evening:            High    Medium            Low
	Lean Muscle Mass?	
	Do you know how many grams of protein you need per day? If so how many grams?	



# Medical Evaluation Package

## DOCUMENT INSTRUCTIONS

Thank you for your inquiry into our programs. We can assure you that our medical organization will provide to you safe, professional, and excellent service that will help you to achieve and maintain your health and wellness goals.

This is our new patient document package. There are several different documents that need to be completed. You may opt to return them to us via fax at **480-477-6332**. Specific document details and instructions are described below.

### CONFIDENTIALITY STATEMENT

This document details HIPPA confidentiality and secures your privacy.  
*(Signature required and fax back to us)*

### HEALTH PROFILE / QUESTIONNAIRE

This document is required so that our medical staff can review and understand your current health and past health history. *(To be completed by you and faxed back to us)*

If you have questions at any time or require assistance with any of the documents please contact us directly at 480-477-6334 and one of our medical personnel will assist you.

Thank you again for your inquiry and we look forward to working with you.

Sincerely,

**Your Vital Solutions Team**





# CONFIDENTIALITY STATEMENT

Your health is a serious personal matter and we understand that confidentiality is of utmost importance. To ensure your complete privacy, we implemented and follow specific strict security protocols and processes.

We only use the highest level of customer and web site security features to guarantee your privacy and security. It is our policy to never allow any 3rd party access to any of your personal financial or medical information. If you have a question on our security processes or protocols please contact us immediately.

## **You privacy is important to us and we use every care to secure your privacy rights!**

### **HIPAA: Health Insurance Portability and Accountability Act**

This notice describes how medical information about you may be disclosed and how you can get access to this information. Please review this carefully.

In compliance with the 1996 Congressional act to protect the privacy of patients protected health information, we will safeguard all client/patient information and will disclose or share only minimal information necessary for the following purposes:

**Treatment:** Information regarding current or past health information necessary for the agency to carry out appropriate care of the clients requesting home care services which may included but is not limited to: History and physical, progress notes, laboratory reports, x-ray reports, operative reports, consultation reports, hospital discharge reports, hospital DNR , to be obtained from any clinic, hospital, skilled nursing facility, physician office or health care agency involved in the patient/client's present and future care.

**Operations:** Review of medical records by any peer review organization, accrediting body, state or regulatory body for statistical or agency evaluation purposes only. Any information disclosed will be held in strict confidence and not used for any public disclosure.

If you feel that your privacy rights have been violated you may contact us and ask for the Director of Operations. The director will investigate all claims and will provide you with a written report of their findings within 10 days. If you are not satisfied with the report and corrective action taken, the Director will provide you with an appropriate state or federal organization address and or telephone numbers to file a complaint.

We will maintain a log for each patient we service which will list what information was released and for what purpose. The patient has the right to review this log upon request.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date





# HEALTH PROFILE/QUESTIONNAIRE

CONFIDENTIAL MEDICAL HISTORY

<b>PATIENT INFORMATION</b>	Last Name	First	MI	Female ( ) Male ( )	Birth Date	Age
	Address	Apt#	City	State	Zip	
	Home Phone	Cell Phone		Work Number		
	E-Mail			Marital Status	Social Sec #	
	Height	Weight	Goal Weight?			
	Emergency Contact		Relationship			Phone

## Medical – Social History

Do you use tobacco?  Yes  No Frequency \_\_\_\_\_ Quantity \_\_\_\_\_  
 Do you use alcohol?  Yes  No Frequency \_\_\_\_\_ Quantity \_\_\_\_\_  
 Do you use caffeine?  Yes  No Frequency \_\_\_\_\_ Quantity \_\_\_\_\_  
 Do you use recreational drugs (e.g. marijuana, cocaine,, etc.)  YES  NO  Previously  
 If yes # of years \_\_\_\_\_ Year Quit \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ **Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Medical Conditions/Diseases:** Please check all that apply to you.  **None**

<input type="checkbox"/> Heart Disease (Ex: Congestive Heart Failure)	<input type="checkbox"/> Blood Clotting Problems	<input type="checkbox"/> Cancer
<input type="checkbox"/> High Cholesterol or Lipids (Ex: Hyperlipidemia)	<input type="checkbox"/> Arthritis or Joint Problems	<input type="checkbox"/> Depression
<input type="checkbox"/> High Blood Pressure (Ex: Hypertension)	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Lung Condition (Ex: Asthma, Emphysema, COPD) (Glaucoma, etc)	<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Eye Disease
<input type="checkbox"/> Ulcers (Stomach, Esophagus)	<input type="checkbox"/> Hormone Related Issues	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Diabetes	Other: Please list: _____	

**Current Prescription Medications:**  **None**

Medication Name	Strength	Date Started	Times Per Day

**Allergies to Medications:**

**None**

Drug

Type of reaction (e.g. hives, wheezing, swelling, upset stomach, etc.)

**Over the Counter Medicines (e.g., aspirin, Tylenol, Aleve, Ibuprofen, vitamins, herbals, etc.)**

**None**

**Have you had any of the following tests performed:** Check all that apply and list date.

Mammography

No  Yes

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

PAP Smear

No  Yes

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

PSA (males)

No  Yes

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

**Surgical History (e.g., hernia, appendectomy, hysterectomy, etc.)**

**None**

Family History

**Living/Age  
Cause**

**Significant health Problems**

**Deceased/Age**

Father \_\_\_\_\_  
Mother \_\_\_\_\_  
Siblings \_\_\_\_\_  
Children \_\_\_\_\_

**Check if any health problems exist and enter family member(s).**

Health Problem	Family Member(s)	Health Problem(s)	Family Member(s)
<input type="checkbox"/> High blood pressure _____		<input type="checkbox"/> Diabetes _____	
<input type="checkbox"/> Heart disease _____		<input type="checkbox"/> Gastrointestinal _____	
<input type="checkbox"/> Kidney Disease _____		<input type="checkbox"/> Bleeding Problems _____	
<input type="checkbox"/> Cancer _____		<input type="checkbox"/> Other _____	

**Other Concerns/Miscellaneous**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_