Wellness Life Center

Form Name: Wellness Program Fee Form 2

Wellness Program Fee's

Dear Patient

If you have received this information packet, it is because you have expressed desire to benefit from our Specialized Wellness Program. We are excited to offer our area's highest quality medical management in the areas of Functional Medicine and Obesity Medicine. We are trained and certified to provide advanced evaluation and treatment for multiple conditions. We look forward to assisting you in our journey to improved health. Thank you for placing your trust in us.

PLATINUM:
WellLifePro App with open access to all meal plans: $24.99 activation / $9.99 recurring
Initial Medical Consultation with provider (60 minutes) *: $199.00 cash*

Included:

Medical History/Disease Evaluation
Assistance choosing meal plans
Lifestyle Education/planning
Body Composition Analysis
Medication Management
Prescription Therapy
Electrocardiogram
Vitamin Injection
Blood work*

Not included:
Specialty Tests*, based on Provider Evaluation
Subsequent Nurse Visits: $29.00 cash*
Subsequent Office Visits (30 minutes)*:

Included
Continued Medical Evaluation
Medication Adjustments
Body Composition Analysis
Vitamin Injection
Subsequent blood work*
Specialty Tests*

***Insurance may be filed upon request**

Form Name: Wellness Program Patient Questionnaire 2

Patient Information

Name _____ **Date of Birth** _____

Phone _____ **E-MAIL** _____

Address _____

Goal Weight _____ **Height** _____ **Current Weight** _____

Primary Care Physician _____

Allergies _____

Current Medical Problems

If you have any other medical condition that were not reviewed above please list them here: _____

specify other _____

specify other _____

Cancer
☐ Thyroid ☐ Breast ☐ Other

Kidney Problems
☐ History of Kidney Stones ☐ Other

Asthma
○ Yes ○ No

Liver Problems
○ Yes ○ No

Pancreatitis
○ Yes ○ No

Glaucoma
○ Yes ○ No

Situational Stress (please specify) _____

Drug / Alcohol Use (please specify)

Mental Health (select all that apply)

☐ Anxiety ☐ Post Traumatic Stress Disorder (PTSD) ☐ Bipolar ☐ ADHD ☐ Depression ☐ Low Self Esteem

Autoimmune Disease (Please specify)

Irritable Bowel Syndrome

○ Yes ○ No

Diarrhea

○ Yes ○ No

Constipation

○ Yes ○ No

Acid Reflux / Heartburn

○ Yes ○ No

How many hours per night do you sleep?

Sleeping Problems

☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Sleep Apnea ☐ Snoring ☐ Insomnia ☐ Daytime sleepiness ☐ Fatigue ☐ Shift Work

Heart Problems

☐ Chest Pain ☐ Palpitations ☐ Heart Attack ☐ Stents in Heart ☐ Pace Maker

Seizures

○ Yes ○ No

Stroke

○ Yes ○ No

Is your Diabetes controlled with

☐ Diet ☐ Medication ☐ Insulin

Diabetes

○ Yes ○ No

Elevated Blood Sugar

○ Yes ○ No

High Cholesterol

○ Yes ○ No

Medications

List all the supplements/herbal medication you are currently using. (name, dosage, frequency)

Please list all current medications (name, dosage, amount, indication)

Surgical History

Please list out any/all surgeries and approximate dates.

Family History

What is your family health history?

Women Only*

Do you still have a monthly menstrual cycle?

○ Yes ○ No

Menopause

○ Yes ○ No

What age did you go through Menopause?

Did you have a Hysterectomy?

○ Yes ○ No

If yes, please specify the reason for your Hysterectomy.

Drug Use

If yes, please specify type and amount.

If yes, please specify type and amount.

If yes, please specify type and amount.

Do you use any illicit drugs?

○ Yes ○ No

Do you drink alcohol?

○ Yes ○ No

Do you use tobacco?

○ Yes ○ No

Weight Questionnaire

If yes, please explain.

Have you tried other weight loss programs, medications, or weight loss surgery in the past?

○ Yes ○ No

If yes, please explain.

Have you had any traumatic events that contributed to your weight gain?

○ Yes ○ No

At what age did you begin to notice you were gaining weight?

Physical Activity History

What types of physical activity/exercise do you enjoy?

If yes, please explain.

Do you have any medical conditions that prevent you from exercising?

○ Yes ○ No

If yes, what and how often?

Do you exercise or participate in any type of physical activity?

○ Yes ○ No

Nutritional History

What type of foods do you crave? At what time of the day do you have these cravings?

Do you ever binge eat? If so, when?

Please list the types of foods that you eat on an average day.

How many times a day do you eat a snack? Approximately what times?

How many time a day do you eat a meal? Approximately what times?

How did you hear about us?

☐ In the office ☐ Online ☐ Social Media ☐ Word of mouth ☐ Local Advertisement ☐ TV/Radio