Mindspring Health Inc.
1074 Ponce De Leon Ave NE
Atlanta, GA 30306
49B Lenox Pointe NE
Atlanta, GA 30324
404-333-8829 (P)
980-495-8849 (F)
info@mindspringhealth.com

NEW WEIGHT LOSS PATIENT INTAKE FORM

Note: This form supports the initial assessment of patients seeking obesity-related medical care, including consideration for GLP-1 receptor agonist therapy (e.g., semaglutide, liraglutide, dulaglutide, tirzepatide). Please complete all sections accurately. Your information will remain confidential.

First Name: _____ Middle Name: _____ Last Name: _____	Date of Birth: ____ /____ / _____	
Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed	Age: _____	Sex: ☐ Male ☐ Female ☐ Non-binary ☐ Other _____
Race/Ethnicity: _____		

Address and Contact Info

Billing Street Address:_____
City:_____ State:_____ Postal Code:_____
Country:_____ Email _____
Address:_____
Direct Telephone: (_____)_____-_____

Preferred Pharmacy Information

Address:_____
City:_____ State:_____ Postal Code:_____
Country:_____
Direct Telephone: (_____)_____-_____

Please provide information about your primary care physician (PCP): Name/Address/Phone

_____
_____
_____
_____

Emergency Contact Information: Name/Address/Phone

_____
_____
_____
_____

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Chief Concern & Goals

Reason for Visit: *(check all that apply)*

☐ Weight Loss
☐ Weight Maintenance
☐ Management of Obesity-related Conditions (e.g., T2DM, Hypertension, Sleep Apnea)
☐ GLP-1 Therapy Consideration
☐ Pregnancy Planning/Contraception Advice
☐ Other: _____

Weight-related Goals (e.g., % weight loss, BMI target, health outcomes):_____

Interest in GLP-1 Receptor Agonist Therapy? ☐ Yes ☐ No ☐ Undecided
Desired Timeframe to Achieve Goals: _____weeks/months

Past Medical History:
Medication Allergies _____ Other Allergies _____ Current Weight _____
Height _____ Date & Location of last physical exam _____
Have you had a recent EKG? ☐ Yes ☐ No If Yes, was the EKG ☐ Normal ☐ Abnormal
When?_____

Please list all current medical problems:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please check all medical problems that you or a family member has had in the past?			
	You	**Family**	**Which Family Member?**
Thyroid Disease	☐	☐	
Stroke	☐	☐	
Osteoarthritis	☐	☐	
Eating Disorders	☐	☐	
Anemia	☐	☐	

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Liver Disease	☐	☐	
Chronic Fatigue	☐	☐	
Kidney Disease	☐	☐	
Diabetes	☐	☐	
Prediabetes	☐	☐	
Asthma/respiratory problems	☐	☐	
Stomach or intestinal problems (inflammatory bowel, GERD, Celiac)	☐	☐	
Gallbladder Disease	☐	☐	
Cancer (type)	☐	☐	
Fibromyalgia	☐	☐	
Heart Disease	☐	☐	
Autoimmune Disorders (lupus, multiple sclerosis)	☐	☐	
Seizures	☐	☐	
Chronic Pain	☐	☐	
High Cholesterol	☐	☐	
High Blood Pressure	☐	☐	
Dyslipidemia	☐	☐	
Head Trauma	☐	☐	
Genetic disorder (e.g. sickle cell, cystic fibrosis)	☐	☐	
Migraines	☐	☐	
Skin problems (eczema, psoriasis)	☐	☐	
Sleep Apnea	☐	☐	
PCOS	☐	☐	
Psychiatric Conditions (type)	☐	☐	
Other (please list):	☐	☐	

Review of Systems:

Gastrointestinal: Have you had problems with a sensitive stomach, reflux, diarrhea, constipation, or ulcers? ☐ Yes ☐ No
Any history of ulcers? ☐ Yes ☐ No
Problems with high or low blood sugar? ☐ Yes ☐ No

Hormonal: Have you had any problems with weight gain, dry skin, or sluggishness? ☐ Yes ☐ No
Did you develop normally into adolescence? ☐ Yes ☐ No
For women: do you have normal menstrual cycles? ☐ Yes ☐ No

Immune: Do you get sick and catch colds easily or frequently? ☐ Yes ☐ No
Have you taken a lot of antibiotics in your life? ☐ Yes ☐ No

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Do you have problems with seasonal or food allergies? ☐ Yes ☐ No

Musculoskeletal: Do you have any problems with achy muscles or joints? ☐ Yes ☐ No
Weak bones? ☐ Yes ☐ No

Genitourinary: Do you experience problems with urination, water balance? ☐ Yes ☐ No
Any problems with libido and/or sexual function? ☐ Yes ☐ No
Any history of bladder or kidney infections? ☐ Yes ☐ No

For women only:
Date of last menstrual period _____
Are you currently pregnant or think you might be pregnant? ☐ Yes ☐ No
Are you planning to get pregnant in the near future? ☐ Yes ☐ No
Birth control method _____
How many times have you been pregnant? _____ Full term births _____ Preterm births _____
Abortions/miscarriages _____ Living children _____
Have you gone through menopause? _____ When? _____

Current Medications:

Please list your current medications **(include prescription, over the counter, supplements and herbs)**:

Medication	Dosage & Frequency	Reason for Medication	Is it helpful?

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Current Symptoms & Body Metrics

Height: _____ Weight: _____ Target Weight: _____
Waist Circumference: _____ BMI: _____
Obesity-related Symptoms: *(check all that apply)*
☐ Fatigue ☐ Breathlessness ☐ Joint Pain ☐ Sleep Disturbances ☐ Digestive Changes

Lifestyle & Treatment Preferences

Typical Diet:
_____
_____
_____

Physical Activity Level: ☐ Sedentary ☐ Light ☐ Moderate ☐ High
Average Sleep: _____ hours/night
Stress Management Techniques:
_____
_____
_____

GLP-1 Therapy Preferences

Preferred Agent (if known): ☐ Semaglutide ☐ Others: _____
Preferred Administration: ☐ Injection ☐ Oral

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Consent

Is there anything else I should know that doesn't appear on this form or other forms, but that is or might be important?

_____
_____
_____
_____
_____
_____

My signature below indicates that I have voluntarily and accurately completed the New Patient Intake Form.

_____	_____	_____
Patient Name	Signature	Date