13838 S. 46th Pl, #320
Phoenix, AZ 85044
ahwatukeeweightloss@gmail.com

AHWATUKEE
WEIGHT LOSS

James R. Nichols, MD
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(480) 759-5151

Weight Loss Program Questionnaire

Name:_____ Date of Birth:_____ Age: _____ Sex: ☐ Female ☐ Male

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Work Phone:_____ Email:_____

Emergency Contact Name:_____ Emergency Contact Phone:_____

How did you hear about this clinic? ☐ Social Media:_____ ☐ Referral:_____
☐ Internet Search ☐ Billboard/Ad ☐ Other:_____

What are your main motivating factors for wanting to lose weight?

_____

What reasons do you feel contribute to having excess weight? Check all that apply:

☐ Alcohol Intake ☐ Comfort Foods ☐ Hormone Changes ☐ Medical Condition ☐ Sedentary Lifestyle
☐ Busy Lifestyle ☐ Excess Snacking ☐ Increased Stress ☐ Perimenopause ☐ Sweetened Beverages
☐ Child Birth ☐ Family History ☐ Low Energy/Fatigue ☐ Sleep Disruptions ☐ Other:_____

What foods do you crave the most and how often do you eat these foods?

_____

What methods and/or interventions have you used for weight loss in the past?

☐ Diet Modification ☐ Exercise Programs ☐ Herbal Supplements ☐ Prescription Medication ☐ Talk Therapy

Please explain any items you marked above:

_____

_____

Do you feel you experience any of the following potential obstacles to weight loss?

☐ Binge Eating ☐ Psychological Factors ☐ Skipping Meals ☐ Stress Eating ☐ Unsupportive Partner

Please explain any items you marked above:

_____

How long has weight been an issue?_____ **What is your ideal weight?**_____

Are you currently at your heaviest weight? ☐ Yes ☐ No *If no:* **Heaviest Weight:**_____

1- Do you have known allergies/sensitivities to:

☐ Adhesives ☐ Benzyl Alcohol ☐ B Vitamin Formulations ☐ GLP-1 Receptor Agonists ☐ Latex ☐ L-Carnitine

2- Have you ever fainted during injections or blood draws? ☐ Yes ☐ No

3- Have you ever had an adverse reaction or significant side effects to any weight loss meds? ☐ Yes ☐ No

If you marked an allergy above in line item 1 or marked yes to items 2-3 above, please explain below:

_____

Do you take antidiabetics? ☐ Yes ☐ No If yes, please list:_____

Do you take blood pressure medication? ☐ Yes ☐ No

Do you take any medications that may cause increased risk of bleeding or delayed healing? ☐ Yes ☐ No

If yes, please check all that apply: ☐ Anti-Platelets ☐ Blood Thinners ☐ Corticosteroids ☐ NSAIDS

Female Medical History:

Are you currently: ☐ Pregnant ☐ Trying to conceive ☐ Breastfeeding ☐ Post-Menopause

Birth Control: ☐ Abstinence ☐ Birth Control Pill ☐ Depo Provera ☐ Hysterectomy ☐ IUD ☐ Menopause ☐ Nexplanon ☐ NuvaRing ☐ Tubal Ligation ☐ Vasectomy

☐ Other (Please Explain): _____

Date of Last Menses: _____ **Pregnancies:** _____ **Live Births:** _____

Male Medical History:

Vasectomy? ☐ Yes ☐ No **Trying To Conceive?** ☐ Yes ☐ No

General Medical History:

Have you or a family member ever been diagnosed with:

☐ Medullary Thyroid Carcinoma (Thyroid Cancer) ☐ Multiple Endocrine Neoplasia syndrome type 2 (MEN2)

Have you ever been diagnosed with or currently have:

☐ Adrenal Fatigue/Issues	☐ Congestive Heart Failure	☐ High Blood Pressure	☐ Neurological Disorder
☐ Anemia/Blood Disorders	☐ Diabetes	☐ High Cholesterol	☐ Pancreas Disease
☐ Asthma	☐ Depression	☐ Immune Deficiency	☐ Poor Wound Healing
☐ Autoimmune Disorder	☐ Digestive Issues	☐ Intestinal Issues	☐ Retinopathy
☐ Blood Clotting Disorder	☐ Gallbladder Disease	☐ Kidney Disease/Stones	☐ Stroke/TIAs
☐ Cancer	☐ Eating Disorder	☐ Liver Disease	☐ Thyroid Disease
☐ Chemical Dependence	☐ Heart Disease/Arrhythmia	☐ Mental Health Disorder	☐ Ulcers (Gastric)

Please explain any items you marked above:

_____

_____

Do you have any other medical issues not listed above? ☐ Yes ☐ No

If yes, please describe issue here: _____

Date of last blood work: _____ **Date of last physical:** _____

Describe any abnormal results: _____

_____

Do you consume alcohol? ☐ Yes ☐ No

If yes, please list number of drinks you consume per week: _____

Do you smoke? ☐ Yes ☐ No

If yes, please describe how often and how much you smoke: _____

Do you exercise regularly? ☐ Yes ☐ No

If yes, please describe activity, frequency, and duration:

_____

If there is anything else you'd like the Provider to know, please let us know here:

_____

_____

_____

Patient Name: _____ **DOB:** _____ **Date:** _____

Medication Record

Please list all medications, over the counter drugs, and herbal supplements you are currently taking. Please include any prescription topical creams and hormone replacement therapy medications/implants.

Medication or Supplement	*Frequency*	*Dose*	*Purpose/Prescribed For*

Allergies & Sensitivities

Do you have any allergies or sensitivities to foods, medications, implants, etc? ☐ Yes ☐ No

If yes, please list all allergens and how you react to them:

_____

_____

Surgical History

Have you been hospitalized or received acute medical care, including surgeries, in the past year? ☐ Yes ☐ No

If yes, please describe here: _____

Primary Care Physician: _____ **Phone:** _____

List all surgical procedures you have had with approximate dates:

_____

_____

I affirm the information I have provided regarding my health history, medication record, and prior surgeries and aesthetic treatments is accurate to the best of my knowledge. I acknolwedge that Ahwatukee Weight Loss Staff are not responsible for any errors that may occur as a result of any omissions or incorrect information on this form.

Patient Name (Print) **Patient Signature** **Date**

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Consent To Treatment: GIP and/or GLP-1 RA Weight Loss Injections

Informed Consent Instructions: This is an informed consent document to provide written information about the above named treatment regarding risks, benefits, and alternatives. It is important that you understand the information provided to you prior to proceeding with this treatment; please ask your healthcare professional any/all questions prior to signing this consent form.

Name:_____ **DOB:**____/____/____ **Date:**____/____/____

I, _____ , consent to treatment by Ahwatukee Weight Loss using **Tirzepatide (GIP/GLP-1 RA)/Pyridoxine (B6)** injections for elective chronic weight management treatment. **Treatment benefits** will vary by individual, but may include: reduced appetite, feeling a sense of fullness for longer durations after eating (delayed gastric emptying), and increased fat-burning mechanisms which may result in weight loss. Additional therapeutic benefits related to weight management may include: improved blood sugar levels and reduced risk of adverse cardiovascular events.

Purpose of Treatment and General Information:

What is Tirzepatide Weight Management Treatment: Tirzepatide weight management injections are used for weight loss along with a diet and exercise plan. These injections are delivered beneath the surface of the skin (subcutaneously) for chronic weight management in adults with obesity (BMI >30) or who are overweight (BMI >27) with at least one weight-related condition, including high blood pressure, diabetes type 2, and/or high cholesterol. Tirzepatide mimics both GIP and GLP-1 receptor agonist hormones, which trigger insulin creation, sensation of fullness, and appetite reduction. Additional treatment benefits associated with these weight loss injections may include: improved A1C and blood sugar levels by increasing insulin (a hormone that lowers blood sugar levels) and inhibiting glucagon (a hormone that raises blood sugar); improved blood pressure; reduced risk of major adverse cardiovascular events.

What To Expect During Treatment: Your treatment provider will begin with a consultation that includes blood draws to check lab values and will review your health and medication history to ensure you are a good candidate for weight loss injections. You will be counseled on nutrition and exercise recommendations to be used along with Tirzepatide injections for chronic weight management, including reducing calories and increasing physical activity. You will be taught how to perform these injections at home just below the surface of the skin (subcutaneously) and will be prescribed a dosage that is adjusted for your individual needs, in accordance with your treatment plan. There is no downtime associated with this treatment. **You may feel** minor discomfort during the injection, similar to an insulin injection. **Common side effects** include: nausea, vomiting, diarrhea, indigestion, abdominal pain, constipation, fatigue, and dizziness. **Multiple injections** will be needed over the course of months to achieve desired results.

Continued on next page

What to Expect, continued:

Dosing adjustments will be made by your treatment provider based on your body's response and any side effects you're experiencing. **Treatment Regimen:** Typical treatment regimen includes an initial series of weekly injections for 90 days, including follow-up and lab work. You will return to the office for follow-up visits and dose adjustments until you've reached your weight loss goals. **Maintenance:** Once you have achieved your weight loss goal, you may be weaned down to lower dosing Tirzepatide at specified intervals and/or given a maintenance protocol. **Maintenance injections** may be necessary to maintain desired results.

I understand the treatment goal is weight loss. I understand that repeated injections will be necessary in order to achieve desired results and that I will need to maintain regular follow-ups with my treatment provider.

Initials: _____

Treatment Benefits:

Tirzepatide/Pyridoxine injection benefits may include:

- Weight reduction and/or weight management
- Improved blood sugar
- Reduced risk of adverse cardiovascular events related to obesity

I understand the possible benefits of this weight management treatment. **Initials:** _____

Possible Risks and Side Effects:

Possible side effects/risks of Tirzepatide/Pyridoxine Weight Management Treatment may include:

1. General Side Effects: I understand there is a risk of discomfort, pinpoint bleeding, pain at the injection site, bruising, allergic reaction, damage to deeper structures, or gastrointestinal side effects that may occur.

2. Gastrointestinal Upset: The most common side effects of treatment include: Nausea, vomiting, diarrhea, constipation, indigestion, belching, feeling bloated, and abdominal pain. Slow titration of dosing adjustments may help prevent these side effects, or dosing adjustments may be required if side effects persist. Your treatment provider can provide you with medications and/or recommendations to help alleviate these side effects, including suggesting eating slowly, eating bland foods, avoiding greasy foods, and avoiding lying down immediately after eating.

3. Fatigue, Dizziness, and Headache: Some patients experience fatigue, dizziness, and/or headache, which may be a result of low blood sugar. If you experience these symptoms, please discuss this with your treatment provider.

4. Low Blood Sugar: There is an increased risk of low blood sugar (hypoglycemia), especially in patients with type 2 diabetes taking medications such as insulin or sulfonylureas. Symptoms may include: dizziness, headache, lightheadedness, rapid heartbeat, mood changes, irritability, weakness, shakiness, slurred speech, confusion, or hunger. Talk to your healthcare provider about how to recognize and treat low blood sugar. If you have diabetes type 2, you should check your blood sugar as directed.

5. Increased Heart Rate: You may experience an increased heart rate while at rest. Please contact your treatment provider if you experience your heart racing or if you feel a pounding sensation in your chest that lasts for several minutes or longer.

6. Allergic Reaction or Hypersensitivity: Although rare, allergic reactions or serious hypersensitivity may occur. Signs of allergic reaction may include: hives, difficulty breathing, swelling of your face, lips, tongue, or throat; additional treatment may be necessary should an allergic reaction occur.

7. Runny Nose and Sore Throat: Common side effects include a runny nose and sore throat. Tell your treatment provider if these symptoms persist or become bothersome.

_____ _____

Patient Name (Print) **Date**

Continued on next page

Possible Risks and Side Effects, continued:

8. Bleeding/Bruising/Redness: It is possible to experience minor pinpoint bleeding during and after injection. Bruising in soft tissues may occur, as well as minor redness or swelling.

9. Infection: Although rare, if an infection occurs as a result of treatment at injection site, additional treatment including antibiotics or an additional procedure may be necessary.

10. Pancreatitis: Inflammation of the pancreas (pancreatitis) may occur. If you experience persistent severe pain in your stomach, with or without vomiting, please contact your treatment provider right away.

11. Gallbladder Inflammation and/or Gallstones: You may experience gallbladder issues, including gallstones. Signs/symptoms of gallbladder inflammation and/or gallstones include: pain in your upper stomach, yellowing of skin and/or eyes, clay-colored stools, and fever. Please contact your treatment provider right away if you experience these symptoms. Some gallbladder issues may required additional treatment incurred at your expense, and which may include surgical intervention and/or hospitalization.

12. Gastrointestinal Blockage or Disease: Although rare, there is a risk of stomach blockage (known as a an ileus) resulting from decreased intestinal movement of food and fluids. Symptoms include persistent, unrelieved constipation, stomach cramping and swelling, loss of appetite, inability to pass gas, and vomiting. An ileus can be serious and life threatening if left untreated; treatment may include hospitalization and/or surgery incurred at your expense.

13. Dehydration and Acute Kidney Injury and/or Renal Impairment: There is a potential risk for dehydration leading to acute kidney injury and/or worsening renal impairment due to adverse gastrointestinal reactions (nausea, vomiting, diarrhea). It is important to drink adequate fluids to help reduce your risk of dehydration, which may cause kidney impairment.

14. Thyroid C-cell Tumors: There is a potential risk for thyroid C-cell tumors when taking Tirzepatide. Please report any signs/symptoms of thyroid tumors to your treatment provider, including: persistent hoarseness, shortness of breath, mass in neck, and/or difficulty swallowing.

15. Changes in Vision: Patients with diabetic retinopathy may experience changes in vision while taking Tirzepatide. This may be caused by a rapid improvement in glucose control, which could lead to temporary worsening of retinopathy, however, the effect of long-term glycemic control on diabetic retinopathy has not yet been studied. Please report any changes in vision to your treatment provider.

This list is not exhaustive of all possible risks associated with Tirzepatide/Pyridoxine weight management treatment, as there are both known- and unknown- side effects and risks associated with any medication or treatment.

I have read and understand possible risks, side effects, and complications. **Initials:** _____

Tirzerpatide injections are contraindicated in those who:

- are pregnant or are breastfeeding
- have ever had Medullary Thyroid Cancer (MTC) (this includes a family history of MTC)
- have Multiple Endocrine Neoplasia Syndrome type 2 (MEN 2)
- have ever had a serious allergic reaction to Tirzerpatide or any of the ingredients in Tirzepatide, including compound formulations, which may include: vitamin b12 and/or vitamin b6

Please tell your treatment provider if you have any other medical conditions, including the following, as Tirzepatide injections may not be suitable for you:

- plan to become pregnant (you should stop Tirzepatide 2 months prior to pregnancy)
- have, or have had, problems with your pancreas or kidneys
- have type 1 diabetes, type 2 diabetes, or a history of diabetic retinopathy

_____ **Patient Name (Print)**

_____ **Date**

Continued on next page

Medical Conditions, continued:

- are taking certain medications, including: sulfonylureas or insulin
- have, or have had, depression, mental health issues, and/or suicidal thoughts

I have read and understand the contraindications to treatment and affirm that I do not have any of the aforementioned conditions and have disclosed pertinent medical history to my treatment provider: **Initials:** _____

Possible Medication Interactions and/or Reduced Effectiveness

Prescription and OTC Medication, Herbal and Nutritional Supplements, and Minerals: I understand that certain herbal products, medications, and supplements may affect the way Tirzepatide works, resulting in reduced efficacy of treatment and/or additional side effects. Tirzepatide slows stomach emptying and can affect absorption of oral medications medicines, which may affect the way certain medications work or the effectiveness of medications.

I have read and understand possibility of interactions with treatment. **Initials:** _____

Liability Release Related to Adverse Effects

I assume full liability for any adverse effects that may result from the non-negligent administration of the proposed treatment. I waive any claim in law or equity for a redress of any grievance that I may have concerning- or resulting from- the treatment, except as that claim pertains to the negligent administration of this procedure.

I agree to assume full liability for any adverse effects of treatment. **Initials:** _____

Pregnancy Waiver

I deny the possibility of being pregnant at this time. I understand that Tirzepatide may harm an unborn baby and the safety of the use of Tirzepatide during pregnancy and breastfeeding has not been studied. **If I am unsure of pregnancy, I will request a pregnancy test prior to my treatment.** I further acknowledge that I should stop using Tirzepatide at least 2 months prior to becoming pregnant.

I deny the possibility of being pregnant at this time and acknowledge risk of harm to unborn child while taking Tirzepatide. **Initials:** _____

No Guarantee of Results

In some situations, it may not be possible to achieve desired weight loss results. It is also possible that Tirzepatide/Pyridoxine injections may fail to produce any reduction in weight. Should complications occur, additional- or other- treatments may be necessary. **Tirzepatide/Pyridoxine injections are not a permanent solution for weight management,** and must be maintained with lifestyle and diet modifications; you may also require maintenance injections to maintain desired weight. As a weight management treatment, it is recommended to allow at least 90 days of treatment to achieve results. **Duration of results is unknown and not guaranteed.**

I have read and understand results are not guaranteed. **Initials:** _____

Alternative Treatments:

Alternative forms of non-surgical and surgical treatment consist of: No treatment whatsoever, diet and lifestyle modifications, increased physical activity, other pharmaceutical weight management therapies, and bariatric surgery. Every procedure will involve a certain amount of risk. An individual's choice to undergo a procedure is based on the comparison of the risk to the potential benefit. Although most patients do not experience adverse complications, you should discuss your concerns and potential risks with your treatment provider in order to make an informed decision.

It has been explained to me that alternative treatments are available. **Initials:** _____

_____ **Patient Name (Print)**

_____ **Date**

Consent continued on next page

Financial Responsibility:

By signing below, I acknowledge that I understand the regular charge applies to all treatments. I understand- and agree- that all services rendered to me are charged directly to me and that I am personally responsible for payment. I acknowledge that most insurances do not cover the cost of weight loss injection treatment, and therefore, I am required to pay for services and medication out of pocket. In the event that I am not satisfied with my results, I agree not to seek a refund for Tirzepatide treatment services rendered, as I am fully aware that there is no implied or explicit guarantee of results, as stated in the acknowledgement above. **I further agree in the event of non-payment and/or reversal of payment via a credit card dispute that I initiate, I will bear the cost of collection fees, and/or court fees, and/or any reasonable legal fees resulting from such instance.**

Tirzepatide (GIP/GLP-1 RA)/Pyridoxine (B6) Weight Management Treatment Consent:

By signing below, I acknowledge and agree:

- I have fully disclosed on my client intake form and during face-to-face consultation with treatment provider any and all medications, previous complications, planned or previous surgeries, sensitivities, allergies, or current conditions that may, or may not, affect my treatment.
- I have read the foregoing informed consent for Tirzepatide/Pyroxidine Weight Management Treatment; I agree to the treatment and all known and unknown associated risks.
- I have received and will follow all aftercare instructions.
- I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.
- For women of childbearing age: by signing below I confirm that I am **not pregnant** and do not intend to become pregnant anytime during the course of this treatment and that I am not breastfeeding. Furthermore, I agree to keep my treatment provider informed should I become pregnant during the course of this treatment.
- It has been explained to me in a way that I understand:
  - There may be alternative procedures or methods or treatments.
  - There are risks, known and unknown, to the procedure or treatment proposed.
- I have had ample opportunity to ask any questions regarding Tirzepatide Weight Management Treatment benefits, side effects and after care, and all of my questions have been answered to my satisfaction. I believe I have adequate knowledge to understand the nature and risk of the treatment to which I am consenting.

Patient Name (Print)	Patient Signature	Date

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CLIENT ACKNOWLEDGEMENT AND LIABILITY RELEASE

Treatment Liability Waiver

I acknowledge that elective supplementation therapies, including, but not limited to Tirzepatide/Pyroxidine Weight Management Treatment, may be considered medically unnecessary. It may or may not mitigate, alleviate, or cure the condition for which it has been prescribed. This treatment has been recommended to me in the belief that it is of potential benefit and its use will quite probably improve the condition for which I am under treatment for. Based on the risks and potential benefits of this proposed treatment, I have elected to receive this proposed treatment by providers and staff at Ahwatukee Weight Loss**.**

I understand that I may suspend or terminate my treatment at anytime by informing my medical provider. I assume full liability for any adverse effects that may result from the non-negligent administration of the proposed treatment. I waive any claim in law or equity for redress of any grievance that I may have concerning or resulting from the procedure, except as that claim pertains to negligent administration of this procedure. The risks involved and the possibilities of complications have been explained to me. I fully understand and confirm that the nature and purpose of the aforementioned treatment to be provided may be considered unproven by scientific testing and peer-reviewed publications and therefore may be considered medically unnecessary or not currently indicated.

Therefore, in consideration for any treatment received, I agree to unconditionally defend, hold harmless and release from any and all liability the company and the individual that provided my treatment, the insured, and any additional insured's, as well as any officers, directors, or employees of the above companies for any condition or result, known or unknown, that may arise as a consequence of any treatment that I receive.

I understand and agree that any legal action of any kind related to any treatment I receive will be limited to binding arbitration using a single arbitrator agreed to by both parties.

By signing below, I acknowledge and agree:
I have carefully read the information on this page and understand that I may be giving up some important legal rights by signing.

Patient Name (Print)	Patient Signature	Date
_____	_____	_____