Intake Packet

Simply Well · Compass Medical Clinic

Welcome to Compass Medical Clinic. This packet helps your care team understand your health story fully — so we can build a plan that fits your real life.

This is the beginning of a comprehensive evaluation. We will start with a full medical history and include several screening packets so that we can fully understand you and the potential multifactorial history of your health. Thank you for completing this packet.

Complete these pages at home over the days leading up to your first visit. Answer honestly — there are no right or wrong answers. It is okay to skip questions that do not apply.

HOW TO COMPLETE

Time to complete: approximately 25 minutes. Please return this packet prior to your first appointment.

Visit timing: your first (intake) visit is 1 hour.

Companion documents: this packet is given with the Compass Medical Clinic demographic sheet, Screening Resources for home completion, and the Visit 1 Screening Companion (completed in the waiting room at your first visit). A separate After Your First Visit packet will be given at Visit 1.

WHAT'S INSIDE

A About You

B Why Now

C Weight & Health History

D Medical History

E Family Medical History

F Gynecologic History (if applicable)

CLOSING

- Consent for Comprehensive Cardiometabolic Care
- Consent for Shared Medical Visits

A · ABOUT YOU

FULL NAME

DATE OF BIRTH

PRONOUNS

PREFERRED NAME

DATE OF THIS FORM

PHONE (best number)

EMAIL

PREFERRED WAY TO CONTACT ME

REFERRED BY

REFERRING PROVIDER OR PERSON

PRIMARY CARE PROVIDER (if different)

PCP NAME

CLINIC

EMERGENCY CONTACT

NAME

RELATIONSHIP

PHONE

B · WHY NOW

Understanding what brought you here helps us support you better from the start.

Something has brought you here right now. Take a few minutes to name it in your own words.

What do I want for myself, my life, my health right now?

Start with what you want — not what you should want or what someone else wants for you.

What brought me to this program at this moment?

A specific event, a slow build, a new season of life, a diagnosis — anything.

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If nothing changed in the next year, what would I notice? What would I regret?

C · WEIGHT & HEALTH HISTORY

CURRENT MEASUREMENTS

HEIGHT	CURRENT WEIGHT	WEIGHT 1 YEAR AGO	WEIGHT 5 YEARS AGO

HIGHEST ADULT WEIGHT (and age)	LOWEST ADULT WEIGHT (and age)

MY WEIGHT GOAL	MY REASON FOR THAT GOAL

Goals will be refined together — this is just a starting point.

WHEN DID WEIGHT FIRST BECOME A CONCERN?

Circle the life stage when you first noticed weight becoming a concern.

- ○ Childhood
- ○ Teens
- ○ Young adulthood (20s–30s)
- ○ Middle adulthood (40s–50s)
- ○ After age 60

LIFE EVENTS ASSOCIATED WITH WEIGHT GAIN

Circle any that apply.

- ○ Marriage / partnership
- ○ Major illness or injury
- ○ Quitting smoking
- ○ Divorce / separation
- ○ Loss of a loved one
- ○ Medication change
- ○ Pregnancy
- ○ Job change or job stress
- ○ Sleep problems
- ○ Menopause
- ○ Trauma or abuse
- ○ Mental health changes

Other: _____

WEIGHT HISTORY TIMELINE

Fill in what you remember — approximate is fine.

AGE	YEAR	WEIGHT	LIFE EVENT OR TRIGGER

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AGE	YEAR	WEIGHT	LIFE EVENT OR TRIGGER

PREVIOUS PROGRAMS AND DIETS I HAVE TRIED

Circle any that apply.

- ○ Weight Watchers / WW
- ○ Nutrisystem
- ○ Jenny Craig
- ○ Noom
- ○ Atkins
- ○ Keto
- ○ Paleo
- ○ Intermittent fasting
- ○ Low-carb
- ○ Mediterranean
- ○ Meal delivery service
- ○ Other: _____

MAXIMUM WEIGHT LOSS ACHIEVED

HOW LONG DID YOU MAINTAIN IT?

What worked well for you?

What didn't work, or what were your greatest challenges?

C · WEIGHT & HEALTH HISTORY (continued)

PREVIOUS WEIGHT LOSS MEDICATIONS

Circle any medications you have taken — past or current.

- ○ None
- ○ Phentermine (Adipex)
- ○ Contrave
- ○ Qsymia
- ○ Wegovy / Ozempic (semaglutide)
- ○ Saxenda (liraglutide)
- ○ Mounjaro / Zepbound (tirzepatide)
- ○ Xenical / Alli (orlistat)
- ○ Metformin (for weight)
- ○ Topiramate
- ○ Naltrexone
- ○ Other: _____

If you used medications — what was helpful? Any side effects or reasons stopped?

BARIATRIC / METABOLIC SURGERY HISTORY

- ○ No bariatric surgery
- ○ Gastric bypass (Roux-en-Y)
- ○ Sleeve gastrectomy
- ○ Adjustable gastric band
- ○ Duodenal switch
- ○ Other: _____

IF YES · DATE OF SURGERY	SURGEON / FACILITY	RESULT / COMPLICATIONS

CURRENT WEIGHT-RELATED SYMPTOMS

Circle any that apply right now.

- ○ Joint pain
- ○ Fatigue
- ○ Sleep problems
- ○ Reflux / heartburn
- ○ Snoring / breathing issues
- ○ Skin issues (rashes, chafing)
- ○ Difficulty with movement
- ○ Shortness of breath
- ○ Swelling in legs
- ○ Frequent urination
- ○ Sugar cravings
- ○ Other: _____

D · MEDICAL HISTORY

CURRENT DIAGNOSES · CIRCLE ALL THAT APPLY

- ○ High blood pressure
- ○ High cholesterol
- ○ High triglycerides
- ○ Type 2 diabetes
- ○ Pre-diabetes
- ○ Insulin resistance
- ○ Fatty liver (MASH / MASLD)
- ○ Gallstones (history of)
- ○ Pancreatitis (history of)
- ○ Kidney stones (history of)
- ○ PMOS
- ○ Thyroid disease
- ○ Thyroid cancer or nodules
- ○ Heart disease
- ○ Stroke or TIA
- ○ Cancer (specify below)
- ○ Autoimmune (specify below)
- ○ Sleep apnea
- ○ Asthma / COPD
- ○ Glaucoma
- ○ GERD / reflux
- ○ Depression
- ○ Anxiety
- ○ ADHD
- ○ Chronic pain
- ○ Other: _____

OTHER CONDITIONS OR DETAILS

PAST SURGERIES AND HOSPITALIZATIONS

SURGERY OR HOSPITALIZATION	YEAR	REASON / OUTCOME

CURRENT MEDICATIONS · PRESCRIPTION, OTC, SUPPLEMENTS

MEDICATION	DOSE	FREQUENCY	REASON

ALLERGIES · MEDICATION, FOOD, ENVIRONMENTAL

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E · FAMILY MEDICAL HISTORY

Family history helps us understand your risk. Share what you know — approximate is fine.

Parents and siblings — significant health conditions and ages of onset:
Include mother, father, and siblings

TARGETED FAMILY HISTORY SCREEN

Please answer YES or NO for each of the following.

QUESTION	YES	NO
1. Family history of obesity (parent or sibling)	○	○
2. Family history of early heart disease (before age 55 in men, 65 in women)	○	○
3. Family history of early cancer (before age 50)	○	○
4. Family history of thyroid cancer	○	○

DETAILS ON ANY "YES" ANSWERS ABOVE (relative, condition, age)

F · GYNECOLOGIC HISTORY · IF APPLICABLE

Skip this section if it does not apply to you.

MENSTRUAL HISTORY

AGE AT FIRST PERIOD **CYCLE LENGTH (typical)** **LAST PERIOD**

- ○ Regular cycles
- ○ Irregular cycles
- ○ Heavy bleeding
- ○ Painful periods
- ○ Currently pregnant
- ○ Currently breastfeeding
- ○ In perimenopause
- ○ Postmenopausal

- ○ PMS or PMDD
- ○ Not applicable

PREGNANCIES

NUMBER OF PREGNANCIES | LIVE BIRTHS | MISCARRIAGES | C-SECTIONS

PREGNANCY COMPLICATIONS (gestational diabetes, hypertension, other)

CONTRACEPTION

- ○ None currently
- ○ Combined oral contraceptive
- ○ Progestin-only pill
- ○ IUD (hormonal)
- ○ IUD (copper)
- ○ Implant
- ○ Depo injection
- ○ Barrier / other: _____

MENOPAUSE · IF APPLICABLE

AGE AT MENOPAUSE | CURRENT HRT (yes/no, type)

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CONSENT FOR COMPREHENSIVE CARDIOMETABOLIC CARE

Compass Medical Clinic provides comprehensive, evidence-based care for obesity, cardiometabolic disease, and related conditions, integrating principles from obesity medicine and lifestyle medicine. Please read each section below and initial in the space provided.

NATURE OF CARE

Care is delivered through individual medical visits, shared medical visits, and coaching sessions. Treatment integrates the eight pillars of the Simply Well framework — nutrition, movement, sleep, metabolic markers, connection, protection, mind, and balance — with obesity medicine principles.

_____ *I understand the nature of care provided.*

OBESITY AS A CHRONIC DISEASE

I understand that obesity and related cardiometabolic conditions are chronic diseases influenced by genetics, biology, environment, behavior, and other health conditions. Treatment is a long-term partnership. Both active-change and maintenance phases are expected. Weight regain can occur as a biological response and may require ongoing intervention.

_____ *I understand obesity is a chronic disease requiring long-term care.*

TREATMENT APPROACH

My treatment plan will be individualized to my medical history, personal goals, and current evidence. Approaches may include: lifestyle interventions (nutrition, movement, sleep, stress, social connection); behavioral and coaching support; FDA-approved anti-obesity medications; medications for related metabolic conditions (blood pressure, lipids, blood sugar); nutritional supplementation as clinically appropriate; and referral for procedural or surgical treatment when indicated.

_____ *I understand the range of treatment approaches available to me.*

MEDICATIONS

If medications are prescribed, I understand: (1) medications will be selected based on my medical history, contraindications, and treatment goals; (2) all medications carry potential risks and side effects that will be reviewed with me before prescribing; (3) some medications may be used off-label in accordance with current medical guidelines; (4) long-term use may be required to sustain benefit; (5) regular follow-up and monitoring (labs, vitals, symptoms) are essential; (6) I may request to change or stop a medication at any time and will notify my care team. Medication start and adjustment is done best with shared decision making during a medical appointment. Regular follow up is required.

_____ *I understand how medications will be prescribed and monitored.*

LIFESTYLE MEDICINE COMMITMENT

Sustainable improvement in cardiometabolic health depends on my active participation in lifestyle change. My care team will guide, educate, and support these changes; the daily practice is my responsibility. I understand that treatment outcomes depend on many factors, including my engagement with recommended lifestyle changes. Referrals may be done to help support your social determinants of health.

_____ *I understand my active participation is essential to my results.*

MY CARE

My care team is committed to compassionate, patient-centered care. I may raise concerns about my care at any time. Communication is key to our partnership.

_____ *I understand I may raise concerns about my care at any time.*

USE OF SCRIBE OR AI DICTATION

A scribe or AI dictation tool may be used at my visit to help streamline care and allow for more direct connection during our conversation. This consent covers such use. I will inform my care team if I have concerns.

_____ *I understand a scribe or AI dictation tool may be used at my visit.*

By signing below, I acknowledge I have read and understood this consent, have had the opportunity to ask questions, and consent to receive care under the terms described.

PATIENT SIGNATURE _____ DATE _____

PRINTED NAME _____

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CONSENT FOR SHARED MEDICAL VISITS

Some visits in the Simply Well program are Shared Medical Visits (SMVs) — group appointments with other patients who have similar health concerns. Please read each section below and initial in the space provided.

WHAT IS A SHARED MEDICAL VISIT

A Shared Medical Visit is a group appointment where you receive medical care alongside other patients with similar health concerns. These 60 minute sessions combine individual medical assessment, health education, and peer support. Visits are conducted with a care team that includes Dr. Hoover and additional team members such as a medical assistant and/or certified health coach.

_____ *I understand what a Shared Medical Visit is.*

PRIVACY AND CONFIDENTIALITY

Under HIPAA and Oregon law, my health information is confidential. However, in Shared Medical Visits, other patients may hear health information I choose to share. I agree to: respect the privacy of all participants; NOT share names or personal information about others outside the group; and NOT record (audio or video) any portion of the visit.

_____ *I understand the privacy expectations of a Shared Medical Visit.*

MY RIGHTS IN A SHARED MEDICAL VISIT

I control what information I choose to share. I may request a private appointment at any time. I may leave the visit at any time. My medical records remain confidential and are documented separately for each patient.

_____ *I understand my rights during a Shared Medical Visit.*

VIRTUAL / TELEMEDICINE VISITS

If my Shared Medical Visit is conducted virtually: appointments occur by secure video; virtual visits have limitations including possible technical issues and reduced physical examination ability; I must NOT be driving or operating any vehicle during my visit; I must have a private, stationary location with adequate internet or phone service; if I have a medical emergency, I will call 911.

_____ *I understand the terms of virtual visits, if applicable.*

BILLING

Shared Medical Visits are billed to my insurance as standard medical visits. I am responsible for applicable co-pays, deductibles, or co-insurance. I have received the separate Financial Consent form.

_____ *I understand the billing arrangements for Shared Medical Visits.*

CANCELLATION POLICY

I will cancel at least 48 hours prior to my scheduled visit to avoid fees.

_____ *I understand and agree to the cancellation policy.*

By signing below, I voluntarily consent to participate in Shared Medical Visits at Compass Medical Clinic under the terms described above.

PATIENT SIGNATURE _____ DATE _____

PRINTED NAME _____

QUESTIONS? Compass Medical Clinic · (503) 623-1200 · www.compassmed.org