New Wave Weight Loss

Patient information

Patient Name: _____ **Date:** _____

Address_____APT#_____

City_____ State _____ Zip Code _____

Home Phone _____ Work Phone_____

Cell Phone _____ Cell Carrier (if you would like to receive text reminders)

Email Address: _____ Sex M F Date of Birth_____ Age_____
Social Security #_____ Referred By:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Race ☐ Caucasian ☐ African American ☐ Asian ☐ Native American ☐ Latin American ☐ Other ____

Ethnicity ☐ Hispanic ☐ Latino ☐ Non-Hispanic / Non-Latino **Language** ☐ English ☐ Spanish ☐ Other

Occupation_____
Employer_____Emergency Contact: _____
Height: _____Weight _____

Medications: **Reason for taking:**

_____

_____

Health History

◯ Acid Reflux ◯ Allergies ◯ Anemia ◯ Anorexia ◯ Arthritis ◯ Asthma ◯ Bladder ◯ Bowel ◯ Bulimia ◯ Cancer ◯ Chronic Infections ◯ Concussion ◯ Depression ◯ Diabetes ◯ Difficulty Sleeping ◯ Digestion ◯ Dizziness ◯ Elbow/Wrist Pain ◯ Fatigue/Tiredness ◯ Headaches ◯ Heart Disease ◯ Hepatitis ◯ Hernia ◯ High Blood Pressure ◯ High Cholesterol ◯ Immune ◯ Kidney Disease ◯ Knee Pain ◯ Leg/Hip Pain Liver/Gallbladder ◯ Low Back Pain ◯ Neck Pain ◯ Numb/Tingling (Legs/Feet) ◯ Numb/Tingling (Arms/Hands) ◯ Shoulder/Arm Pain ◯ Sinus ◯ Skin ◯ Stroke ◯ Thyroid ◯ Vision ◯ Weight Problems ◯ Electrical stimulation implant ◯ Pancreatitis ◯ Thyroid Cancer

Check off the box below that pertains to you

□ There is a possibility that I may be pregnant at this time*

□ Yes, I am definitely pregnant

□ No, I am definitely not pregnant at this time

Weight Loss Questionnaire

1. Is there a reason you are seeking treatment at this time?

_____

_____

2. What are your goals about weight control and management?

_____

_____

3. Your level of interest in losing weight is:

1 2 3 4 5

Not interested Very Interested

4. Are you ready for lifestyle changes to be a part of your weight control program?

1 2 3 4 5

Not Ready Very Ready

5. How much support can your family provide?

1 2 3 4 5

No Support Much Support

6. How much support can your friends provide?

1 2 3 4 5

No Support Much Support

7. What is the hardest part about managing your weight?

_____

_____

8. What do you believe will be the most helpful in helping you to lose weight?

_____

_____

9. What has been your lowest and highest body weight as an adult?

Lowest: _____ Highest: _____

10. At what age did you start trying to lose weight? _____

11. Please check all previous programs that you have tried in order to lose weight. Indicate dates and length of participation.

Program	Date	Duration (Months)	Weight Lost
Weight Watchers			
Overeaters Anonymous			
Liquid Diets			
Diet Pills (Meridia, Xenical)			
Diet Pills (Phen-Fen, Redux)			
Nutrisystem/Jenny Craig			
OTC Diet Pills			
Registered Dietician			
Obesity Surgery			

12. Have you maintained any weight loss for up to 1 year at any of these programs? Yes No

13. What did you learn from these programs regarding your weight?

_____

_____

14. What did not work about these programs?

_____

_____

15. How important is it that you lose weight at this time?
    a. Not
    b. Not Very
    c. Somewhat
    d. Very Important
    e. Imperative

16. Have you tried to lose weight before? Yes No

17. What factors led to your success?
    a. Encouragement from others
    b. Determination
    c. Goal – Event with old friends, etc.

18. How does being overweight affect you?
    a. Limits exercise
    b. Can't wear my clothes
    c. Tired all the time
    d. My knees hurt
    e. My back hurts
    f. I feel ugly

19. What has made weight loss difficult?
    a. Travel
    b. Holidays
    c. Weekends
    d. Parties
    e. Hunger
    f. Cost of Care
    g. Peer Pressure
    h. Family

20. What is hard about managing your weight?
    a. No will power
    b. I've always been overweight
    c. No exercise
    d. Schedule too busy
    e. Hungry all the time
    f. I don't like vegetables
    g. I'm a meat and potatoes person
    h. I'm addicted to sugar
    i. I like beer

21. Do you follow a special diet?
    a. No
    b. Diabetic
    c. Low Sodium
    d. Low Fat
    e. Kosher
    f. Vegetarian
    g. Other: _____

22. Which meals do you eat regularly?
    a. Breakfast
    b. Brunch
    c. Lunch
    d. Dinner

23. When do you snack?
    a. Morning
    b. Afternoon
    c. Evening
    d. Late Night
    e. Throughout the day

24. What are your favorite snack foods?

    _____

    _____

25. Do you eat out or order food in? Yes No

26. How is your food usually prepared?
    a. Baked
    b. Boiled
    c. Broiled
    d. Fried
    e. Poached
    f. Steamed
    g. Other: _____

27. How many times per day do you have the following items?

Item	Times Per Day
Starch (bread, cereal, pasta, rice, noodles, potatoes)	
Fruit	
Vegetables	
Dairy (milk, yogurt, cheese)	
Meat (fish, poultry, eggs)	
Fat (butter, margarine, mayonnaise, oil, salad dressing, sour cream, cream cheese)	
Sweets (candy, cake, regular soda, juice)	

28. What beverages do you drink daily and how much?

Drink	Times or 8 oz. glasses per day
Water	
Coffee	
Tea	
Soda	
Alcohol	
Other:	

29. Would you like to change your eating habits? Yes No

30. What habits would you like to begin to change?

_____

_____

31. Is your decision to lose weight your own or for someone else?
    a. Mine
    b. My wife
    c. My husband
    d. My parents
    e. My friends

32. Is your family supportive? Yes No

33. What can't you do now that you would like to do if you weighed less?
    a. Ride a bike
    b. Go bowling
    c. Play golf
    d. Go for walks
    e. Play with my children/grandchildren
    f. Get into my old clothes

34. What would you like to get out of this visit regarding your weight?
    a. A diet
    b. Accountability
    c. Understanding about what makes me fat
    d. Medication
    e. Evaluation of what is making me fat

Informed Consent for Weight Management Program

Voluntary Enrollment

I _____ am voluntarily enrolling in the American Weight Loss Program. I hereby authorize Dr. Genet, and her staff to provide support for me to achieve the goals of weight loss and weight maintenance. Such support may include but is not limited to obtaining a complete medical and weight history, a physical examination, appropriate laboratory screening, follow-up visits as per our offices recommendations, direct phone calls, psychological therapy, nutritional counseling, fitness counseling and vitamin supplementation.

Program Purpose and Risks of Obesity

The purpose of enrollment in the program is for the benefit of my overall health and to lose weight. Obesity and being overweight increases my risk for developing heart disease, diabetes, stroke, cancer, and many other diseases. It also reduces my overall life expectancy. I recognize these current risks to my health as unacceptable and wish to aggressively address my weight by enrolling in this program.

No Guarantees

I understand that no guarantee or representation has been made or given to me by anyone as to the results or outcomes of this weight management program. I understand that a major part of the success of the program will depend upon my own personal efforts in following the advice and recommendations I have received as a program participant.

Risks of the Program

I understand that there are some small risks to me in choosing to enroll in this program. These risks include but are not limited to the following:

1) Initially, you might experience some mild fatigue.
2) Headaches in the first week.
3) I understand that regular follow-up calls with your health coach and supervising doctor allows for early detection and management of these possible problems.

General Comments

I understand that the use of the nutraceuticals is part of a comprehensive weight management program and that the medications themselves will not make me lose weight. I understand that to continue to receive appetite suppressants that I must continue to lose weight and continue to make my appointments as scheduled. I understand that in consenting for treatment I agree to pay in full for all visits and charges at the time of each visit. I understand that there are no refunds given at any time for any reason.

Insurance Billing

Health insurance companies do not pay for programs such as this one. I understand that I am personally responsible for payment of all services rendered at this facility for weight management. We do not bill any insurance company for any service rendered at this clinic. We will provide you with a receipt that includes the diagnosis code and charges recorded if you wish to attempt to obtain reimbursement for services rendered on your own including HSA and VEBA accounts.

Signature Attestation

By signing this document below, I certify that I have read and fully understand this consent form. The risks and benefits of enrolling in this program have been explained to me and all my questions answered. I agree not to take any appetite suppressants or other medications for weight management than those prescribed by American Weight Loss. Additionally, I agree to inform American Weight Loss of any changes in medications made by other practitioners I may see, or changes in my general health.

YOUR SIGNATURE BELOW INDICATES YOUR CONSENT TO SUPPORT AND COACHING AND YOUR UNDERSTANDING OF THE STATEMENTS AS MADE ABOVE. IF YOU HAVE ANY QUESTIONS WHATSOEVER CONCERNING THE RISKS, PROPOSED TREATMENT, OR ANY OTHER ISSUE WITH THIS PROGRAM, PLEASE ASK YOUR WEIGHT LOSS CONSULTANT OR SUPERVISING DOCTOR BEFORE SIGNING THIS CONSENT.

Signature _____

Date_____