Healthy Weight 4 Me

Enrollment Application for the New Direction VLCD or LCD

CONFIDENTIAL

DATE: ____________________

NOTE: This form must be completed before you can be enrolled in any program at Healthy Weight 4 Me. Please answer every question and print, type or write clearly.

Name (First-Initial-Last)				
Address (Street-City-State-Zip)			Daytime Phone No.	
Occupation		Name of Employer	Evening Phone No.	
Age	Birth date (Month-Day-Year)	Circle Marital Status Single Married Divorced Separated Widowed		SEX (CIRCLE) MALE FEMALE
Circle Level of Highest Education Completed Grade School High School Some College College Grad Grad School Some Tech School Tech School Grad				
Please give the name and address of a friend or relative with a stable address (for emergency)				
Name (Last-First-Initial)		Address (Street-City-State-Zip)		Phone No.
Have you been treated at this health care facility before? □ Yes □ No				

WEIGHT HISTORY

Patient weight (lbs)	Indicate ages during which you were overweight
Present height (feet, inches)	□ Childhood (Age 2-11 yrs) □ Age 20-29 yrs
What is your goal weight?	□ Adolescence (Age 12-19 yrs) □ Age 30-40 yrs
When did you last weight this amount?	□ Over 40 yrs

How much weight do you expect to lose during this program? _________ lbs.

Which weight loss methods have you tried in the past? Please be as specific as possible (eg. NutriSystem, Jenny Craig, Starvation, Protein Formula, Medications, Spa, Hypnosis, Weight Watchers, Psychotherapy, Etc.)

Weight loss method	How much weight loss How long maintained	Why did you stop treatment?	Problems during treatment
Example: *MediWeight Diet*	*25 lbs. / one year*	*Desired other foods*	*Dizziness*
________________	________________	________________	________________

Which weight loss method do you consider your most successful?

What accounted for that success?

____

____

____

Medical History

Name of Physician to receive your progress reports:		
Name	Office Address	Phone
When was your most recent physical exam and lab testing? Month:	Year:	Where:

Medical History Name:

Are you allergic to any medications? ☐ **Yes** ☐ **No** Which ones?

Please indicate whether you have **ever used** or are **still using** any of the following medications. ***Add** any **other meds** you are on.* Please also include supplements that you are taking.

Ever Used	Still Using	Category	Name	Year Started	Dosage
		Lithium			
		Steroids (shots or pills)			
		Diuretics (Water Pills)			
		Heart or blood pressure meds			
		" " " "			
		" " " "			
		Insulin (types)			
		Diabetes Medication			
		" "			
		" "			
		Thyroid Hormones			
		Birth Control Pills			
		Other Hormones (pills, shots, etc.)			
		Tranquilizers			
		Antidepressants			
		Aspirin			

Circle any of these health problems that apply to you:

Pre-diabetes Diabetes High blood pressure
Heart Problems Sleep Apnea CPAP use
Asthma Lung disease Kidney disease Gout

Arthritis-what joints?________________________________
Low Back problems? ________________________________
____

Please check any health condition you have:

☐ Heart attack within last 3 months	☐ Peptic ulcer disease that is not resolved or under good control
☐ Insulin-dependent diabetes (juvenile-onset diabetes)	☐ Recent onset of inflammatory bowel disease
☐ Liver disease requiring protein restriction	☐ Non-insulin dependent diabetes
☐ Pregnant or planning to become pregnant within 6 months	☐ Gestational Diabetes
☐ Kidney disease requiring protein restriction	☐ Other (Explain)
☐ Recent treatment for cancer (please describe)	Date of most recent menstrual period ____________
☐ Recent uric acid kidney stone or untreated hyperuricemia or gout	Number of pregnancies ___________
	Weight gain with pregnancies ___________ lbs. How many Living children ___________

Have you had any of the following surgery? (please circle):

☐ Gallbladder	☐ Heart surgery
☐ Heart stents	☐ Back/spine surgery
☐ Joint replacement	☐ Knee surgery
☐ Gastric bypass/sleeve/stapling/Lap Band	☐ Cancer surgery
☐ Hysterectomy Do you still have ovaries? ☐ Yes ☐ No	☐ Thyroid surgery
Please list any other hospitalizations you have had and when:	☐ Other surgeries:

Name: ______________________________

FAMILY HISTORY:

	Age	Health	Illness	Cause of Death	Overweight
Mother	____	_______	__________________	______________________	Yes No
Father	____	_______	__________________	______________________	Yes No
Brothers	____	_______	__________________	______________________	Yes No
	____	_______	__________________	______________________	Yes No
	____	_______	__________________	______________________	Yes No
Sisters	____	_______	__________________	______________________	Yes No
	____	_______	__________________	______________________	Yes No
	____	_______	__________________	______________________	Yes No

Has any blood relative ever had any of the following? (please circle)

Heart disease Stroke Diabetes Asthma Kidney disease High blood pressure

Psychiatric disorder Epilepsy Cancer Glaucoma

SOCIAL HISTORY

Are you at present undergoing any major lifestyle changes (e.g., marriage, divorce, job change, death of someone important to you)? If so, describe:

What other commitments do you have that might interfere with your fully participating in the New Direction System?

What benefits do you hope to gain from being in this program other than losing weight?

Who do you feel will be supportive of your weight loss and changes in lifestyle? (circle and name your choices)

Spouse Children Roommate(s) Parent(s) Friend(s) Co-worker(s) Other

List five reasons you think it is important for you to lose weight. Please number the reasons, with "1" being the most important.

1.
2.
3.
4.
5.

Why did you choose this particular program?

Referred by whom?

Are you currently in or have you ever had any kind of psychotherapy? □ Yes □ No
If yes, please specify:

With whom	For what	Date treatment began

Have you ever had any kind of alcohol or drug dependence? □ Yes □ No
If yes, please specify:

Treatment		Date treatment began	Ending date

Have you ever been hospitalized for psychiatric reasons? If so, please complete the following:

Dates of Admission	Length of Stay	Reason for Hospitalization

Name: ______________________________________

LIFESTYLE AND EATING HABITS

Do you drink alcohol? ☐ Yes ☐ No ☐ Rarely

If yes, how much?

- ☐ 1-2 drinks a day
- ☐ More than 3 drinks per day
- ☐ 1-2 drinks a week
- ☐ 1 drink a month

Do you smoke or use any form of nicotine? ☐ Yes ☐ No

Did you ever smoke? ☐ Yes ☐ No

Do you use marijuana? ☐ Yes ☐ No

How often do you exercise?

☐ Never ☐ Rarely ☐ Occasionally

- ☐ 1-2 times a week
- ☐ 3-4 times a week
- ☐ 5 or more times a week

What kind of activities would you or do you prefer?

Have you ever been advised not to exercise? ☐ Yes ☐ No

Is there any reason you should not exercise? ☐ Yes ☐ No

How many meals per week do you eat in a cafeteria or restaurant? How many at fast food restaurant?

Are the majority of these meals with friends or family? ☐ Yes ☐ No

Do you skip any meals? ☐ Yes ☐ No What is your typical breakfast?

Typical lunch? Typical supper?

Do you snack? ☐ Yes ☐ No Typical snacks?

Of the following, check all the items that you feel help explain or describe your eating habits:	
☐ Thinking about food too much of the time	☐ Eating to take my mind off other problems
☐ Eating high-fat food	☐ Not paying attention to what I'm eating
☐ Eating too many sweet foods	☐ Overeating at social events
☐ Eating too quickly	☐ Lack of satisfaction in life
☐ Uncontrollable binges	☐ Eating in reaction to boredom
☐ Eating in reaction to tension and depression	☐ Eating in the middle of the night
☐ Overeating when alone	☐ Other:
☐ Using food as a reward	

Do you have allergy or sensitivity to any foods or chemicals?					
Chocolate?	☐ Yes	☐ No	Nutrasweet, Equal?	☐ Yes	☐ No
Dairy?	☐ Yes	☐ No	Splenda (sucralose)?	☐ Y es	☐ No
Soy?	☐ Yes	☐ No	Latex?	☐ Yes	☐ No
Wheat?	☐ Yes	☐ No			
Eggs?	☐ Yes	☐ No			

By signing this form, I certify that the information on this form is true and correct to the best of my knowledge. I also acknowledge that I am aware that there is a copy of the HIPAA Privacy Notice displayed in the office of Healthy Weight 4 Me and that I may have a personal copy upon request.

______________________________ ______________________

Signature Date

I give permission for the data provided in this from and obtained in subsequent visits and interviews to be submitted to Robard Corporation, Division of Food Sciences, for the purpose of group evaluation of data. Except for the purpose of matching current and future data, my name will not be used in conjunction with any of the data. I understand that such group evaluation may, from time to time, be used in publications or other materials, but that my confidentiality will be maintained and my name will never be used.

______________________________ ______________________

Signature Date