Progressive Medical Associates Weight Management
13220 Rosedale Hill Avenue, Huntersville, North Carolina 28078

Your appointment is scheduled on: ____

Please try to arrive 15 minutes early in order to allow time for your full visit. If you are not able to keep the appt, please let us know within 24 hrs by calling 704-766-0320. A cancellation fee of $75.00 will apply if cancellation is not received within 24 hours.

Please bring this information with you to your appointment. The information packet is helpful as it allows more discussion time with you at your initial visit. If you have any outside labs, then bring the most recent copy with you to the visit to avoid additional labs.

Location: 13220 Rosedale Hill Avenue, Huntersville, North Carolina, 28078

Labs: Labs may be obtained at the initial visit and any previous labs will be reviewed so they are not duplicated. It is important that you are fasting (not consumed any food or drink other than water in the last 6 hours) so that the labs are accurate. You may have had fasting labs recently, but possibly the labs considered at this visit were not included in a set of previous "fasting" labs. You do not need to arrive fasting if you are diabetic. If your appt is late in the day, then you can return another day for fasting labs so you do not have to fast all day. **If you are not a patient of Progressive Medical, and have had labs in the past 3 months, please try to bring a copy so labs are not duplicated.**

What to expect: Your initial visit will be about 45 minutes. A follow-up visit is scheduled in 2-4 weeks based on your visit and these visits are 15-20 minutes. We will discuss lifestyle modifications, incorporate this into a plan, and determine follow up visits at the initial visit.

Fees: Visits are billed based on individual insurance plans. Visits are treated as if you were visiting your primary care provider, not a specialist. It is important that you are also familiar with your insurance plan. Your initial visit will be billed at a higher rate as it is a lengthy consult. Follow up visits are billed at a lower rate and are 15-20 minutes.

At your initial consultation appointment we are going to be performing a **body composition analysis** for you using our latest equipment, the InBody 230.
In order for this test to be performed with adequate results, the following guidelines need to be met.
Do not eat any food for 4 hours prior to your appointment time
Do not drink caffeine (sodas, coffee, tea, etc…) on the day of your appointment
Do not drink alcohol for 24 hours prior to your appointment time
Do not exercise for 12 hours prior to your appointment time
Hydrate with water well the day before your test
Insure access to both feet with removable footwear (must have bare feet on machine)
Do not put lotion on hands and feet day of appointment

I look forward to meeting you. My goal is to create a comfortable environment so we can unravel what has not worked and create a plan and lifestyle change that will work long term. Weight loss and weight maintenance is specific to each person and this is why an individual assessment is important. We will discuss nutrition, lifestyle, medications, and anything that could be making it difficult to lose weight or maintain weight loss. I will communicate with your primary care provider if necessary so we can work together to support your success long term.

Dr Cathy Head, DNP, ANP-BC
Nurse Practitioner

Progressive Medical Associates, PLLC

PATIENT REGISTRATION INFORMATION

PATIENT NAME: ____ ❑ M ❑ F
(Last) (First) (Middle)

ADDRESS: ____CITY: _______________ STATE: ____ ZIP _______

BIRTHDATE: ___/_____/________ SSN: __________________ EMAIL ADDRESS: ________________________________

CELL PHONE: ___________________________________ HOME PHONE: _________________________________

MARITAL STATUS: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widow PREFERRED LANGUAGE: _______________

RACE: ❑ White ❑ Black or African American ❑ Asian ❑ American Indian or Alaskan Native ❑ Native Hawaiian or Pacific Islander
❑ White Hispanic or Latino ❑ Black Hispanic or Latino

DO YOU HAVE ANY SPECIAL COMMUNICATION REQUIREMENTS (hearing, vision, trouble understanding)? ❑Yes ❑No

EMERGENCY CONTACT PERSON _____________________________________ RELATIONSHIP ___________________

ADDRESS: ____ TELEPHONE: ____________________

PREFERRED LOCAL PHARMACY: ________________________________ Address: _______________________________________

MAIL ORDER PHARMACY: (If you have one): ____

PRIMARY INSURANCE ______________________________ NAME OF POLICY HOLDER _________________________
INSURED'S ID # ____________________GROUP # ______________ BIRTHDATE OF POLICYHOLDER: ______________
SECONDARY INSURANCE ____________________________ NAME OF POLICY HOLDER _________________________
INSURED'S ID # __________________ GROUP # _____________ BIRTHDATE OF POLICYHOLDER: ________________

WILL THE PATIENT BE THE FINANCIALLY RESPONSIBLE PARTY: ❑Yes ❑No

IF NO, WHO WILL BE THE FINANCIALLY RESPONSIBLE PARTY? ____

RELATIONSHIP TO PATIENT: ______________________ SSN # :___________________ PHONE_____________________

ADDRESS ____

NOTICE OF PRIVACY PRACTICES:

❑ You were provided with a document entitled "Notice of Privacy Practices." It is required that all medical facilities provide you with this notice. Please check the box to acknowledge that you have read (or had the opportunity to read if you choose) and understand the notice. This is a copy of the notice that is yours to keep. If you do not want the copy, you may return it to the receptionist.

INSURANCE INFORMATION & OFFICE POLICIES:

❑ Please check the box to acknowledge that you have been given a copy of our insurance information & office policies.

NUMBER TO LEAVE PRIVATE MEDICAL MESSAGES: Please indicate whether we may leave voice mail messages that may contain private medical information such as lab or test results, medications, etc:

❑ YES, I agree to receive private medical messages at the following phone number: _______________________________
❑ NO, do not leave voice mail messages containing private medical information.

I understand my insurance coverage is a relationship between my insurance company and myself, and I agree to accept financial responsibility for charges incurred that are not reimbursed by my insurance company. I understand that I may be billed for "no-shows" or late cancellations. If I am signing on behalf of a patient under the age of 18, I understand that my financial responsibility will remain in force until I notify the practice in writing.

PRINTED NAME of PATIENT: ____ DATE: ____________________

SIGNATURE (Patient or financially responsible party): ____

(If patient is under the age of 18, must be signed by financially responsible party)

Progressive Medical Weight Management
Patient Medical History Form

Name: ____ Age: ____________ Sex: M F

This information will assist us in developing a particular medical management plan just for you. Thank you for your time and patience in completing this form.

Medical History:

Are you seeing another physician(s) in addition to your primary care physician? Yes No

If yes, list name and reason.

Provider	Reason

Are you taking any medications at the present time? (*including vitamins and supplements)*

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Any allergies to any medications? Yes No

If yes, please list:

Heart and Circulation:

History of high blood pressure?	Yes	No
High cholesterol?	Yes	No
Heart Failure?	Yes	No
History of heart attack or chest pain or other heart condition?	Yes	No
Have you ever had a heart stress test or heart catheterization?	Yes	No

Lungs and Breathing:

Have you ever been diagnosed with sleep apnea?	Yes	No
Do you use a CPAP or BIPAP machine?	Yes	No
Asthma?	Yes	No

Liver, Gallbladder, Stomach, Intestine:

Heartburn/Reflux – If yes, how many times per week? _______ Yes No

Crohns/ulcerative colitis/irritable bowel? Yes No

Endocrine:

Diabetes? If yes, when diagnosed _____________ Yes No

Thyroid disease? Yes No

Polycystic ovarian disease? Yes No

Miscellaneous:

Anemia? Yes No

Depression? Yes No

Other psychiatric disorder? Yes No

Kidney stones and/or other kidney disease? Yes No

Pregnancy History:

Infertility? Yes No

History of gestational diabetes? Yes No

Surgical History:

____

____

____

Social History:

Check all that apply

Married: _______ Partner/Significant Other: ______ Single: ______ Currently smoke? Yes No

Children: Yes No Number of Children: ________ Occupation: ____

Do you drink alcohol? Yes No Indicate the number of drinks per week: _____________________

Family History: ***List any immediate family (parents or siblings) if any of the following apply and place a check.***

Family Member	Heart Disease	Heart Attack (Age)	Diabetes	Elevated Cholesterol	Hypertension	Overweight

Nutrition Evaluation:

1. Present Weight: __________ Height (no shoes): ___________
2. What is the main reason for your decision to lose weight? ____________________
3. When did you begin gaining excess weight? (Give reasons, if known): ____________________

    ____

4. What has been your maximum lifetime weight (non-pregnant) and when? ____________________

5. Previous diets you have followed: Give dates and results of your weight loss:

    ____

    ____

    ____

6. How often do you eat out lunch? None _____ 1-2 x/wk ______ 3-4x/wk______ >5x/wk _____
7. How often do you eat out dinner? None _____ 1-2 x/wk ______ 3-4x/wk______ >5x/wk _____
8. How often do you eat "fast foods?"____________________
9. Food allergies/Intolerances: ____________________
10. Food(s) you crave: ____________________
11. When is your greatest time of hunger? ____________________
12. **Calorie containing** beverages such as soda, sports drinks, or juice **consumed per day** (in oz) ______
13. Diet beverages such as diet soda _______ (per day) **Regular sodas** ________ (per day)
14. Do you drink alcohol? Yes No What? ___________________ How much daily? ___________

Emotional Eating:

1. Are there any emotional factors that influence your eating? Yes No
2. Do you get up and eat during the night? Yes No
3. Do you struggle with hunger? Yes No
4. Do you get most of your calories after 5PM? Yes No
5. Do you ever eat until you feel miserable or lose control of eating? Yes No
6. Are emotions a factor in choices or portion sizes? Yes No
7. List any comfort foods you choose when feeling these emotions: ____________________

____

8. What do you feel have been barriers to losing weight? ____________________

____

Dietary recall (Please list 3 different choices for each meal. Also, list the times you eat. Be as specific as possible listing food and amount.

This is very helpful to know if you skip meals, portion sizes, eat out, etc. to develop a plan that would best support you.

	Breakfast	Mid am Snack	Lunch	Mid afternoon Snack	Dinner	Evening Snack
Ex:	1 egg, 1 c. grits, 8 qz juice	None	Chick fillet grilled chicken sandwich, small fries, 16 oz sweet tea	Small bag of M & M's, diet coke	1 piece fried chicken breast, green beans, mashed potatoes, 16 oz unsweet tea	1 apple, 4 oz whole milk

<u>Exercise Evaluation</u>

Are you currently active? Yes_______ No______ Is fatigue an issue? Yes______ No ______

If not, what are barriers to being active? ____

What type of exercise are you doing? ____

____

How many times a week to you exercise 1-2 days _____ 3-4 days ____ 5-6 days ______

How long is each workout session? Less than 30 min _____ 30-60 min _____ longer than 60 min _____

Do you experience shortness of breath while walking? Yes ____ No ___

Are you able to walk up a flight of stairs? Yes ____ No ____

Willingness and level of commitment to exercise in order to create and maintain a healthy lifestyle.

1 2 3 4 5 6 7 8 9 10

Not very committed Committed