Virtua

Medical Weight Loss

SCREENING APPLICATION

NOTE: THIS APPLICATION MUST BE COMPLETED BEFORE YOU CAN ENROLL IN THE NEW DIRECTION (ND) SYSTEM. PLEASE ANSWER EVERY QUESTION. PLEASE PRINT CLEARLY.

Date: _____

Name (Last Name, First Name):_____

SSN #: _____**Date of Birth:** _____**Age**: _____Sex: □ M □ F□ **Other**

Address: _____ Home phone: _____

_____ Work phone: _____

_____ Cell phone: _____

_____ Email: _____

Primary Physician: _____ Phone: _____

Primary Physician Office Address: _____

How did you hear about us? _____

If we need to leave a message with personal medical information, what number may we use? _____

Emergency contact: _____Relationship:_____ Phone: _____

The Medical Weight Loss Program utilizes Meal Replacements and/or Medications as a tool to aide in weight loss, please indicate which are you interested in including in your treatment plan (Check one)

_____ I am interested in utilizing FDA approved medications as part of my treatment plan

_____ I am interested in utilizing meal replacements as part of my treatment plan

_____ I am NOT interested in utilizing meal replacements OR FDA approved medications and would like to work with a dietitian specifically on eating habits and lifestyle to lose weight without medications or meal replacements in my treatment plan.

INSURANCE INFORMATION

Primary Insurance: _____Group#: _____ID#:_____

Subscriber's Name and date of birth: _____

Relationship to Subscriber: _____ Effective Date: _____

Secondary Insurance: _____ Group#: _____ ID#: _____

Subscriber's Name and date of birth: _____

Relationship to Subscriber: _____ Effective Date: _____

Preferred Pharmacy #1: (name / zip code / phone number) _____

Preferred Pharmacy #2: (name / zip code / phone number) _____

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MEDICAL HISTORY:

Please indicate if you have/ had medical problems noted below:

	Y	N		Y	N		Y	N
ADD/ADHD			Eating Disorder			**Liver disease requiring protein restrictions**		
Allergies			Fibromyalgia			Migraine/ Headache		
Anemia			GERD			Osteoarthritis		
Anxiety			Glaucoma			Pregnant or planning		
Arthritis (GOUT)			Hearing loss			Rheumatoid Arthritis		
Asthma			Coronary artery disease			Seizure disorder		
Bleeding Disorder			Heart murmur			Sleep Apnea		
Cancer treatment (ACTIVE)			HIV/AIDS			Stomach Ulcer (ACTIVE)		
Clotting Disorder			High Blood Pressure			Stroke		
Chronic constipation			High Cholesterol			Substance abuse		
Depression			**Kidney disease or dialysis treatment**			Thyroid disease		
Diabetes type 1			Kidney stone			Active flare of Crohn's or ulcerative colitis		
Diabetes mellitus (type 2)			**Kidney disease requiring protein restrictions**			OTHER HISTORY		
OTHER HISTORY			OTHER HISTORY			7.		
1.			4.			8.		
2.			5.			9.		
3.			6.			10.		

PAST SURGICAL HISTORY:

PROCEDURE TYPE:	**DATE:**

*Do you smoke cigarettes or use tobacco products? _____ If so how much/how many years? _____

*Former smoker / Date quit _____

*Any history of drug abuse or dependence, including recreational drugs and pain medications?

_____

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MEDICATION LIST:

CURRENT MEDICATIONS: PLEASE FILL OUT OR ATTACH LIST		
DRUG NAME:	**DOSE:**	**FREQUENCY:**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
OVER THE COUNTER, HERBALS, VITAMINS: **DRUG ALLERGIES: PLEASE LIST ALL ALLERGIES AND REACTIONS**		

DRUG ALLERGIES: PLEASE LIST ALL ALLERGIES AND REACTIONS

Including (milk protein, lactose intolerance, latex, soy, foods, eggs, corn, aspartame, stevia, chocolate)	
1.	**4.**
2.	**5.**
3.	**6.**

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WEIGHT HISTORY:

Which weight loss methods have you tried in the past? (please be as specific as possible)Example: NutriSystem, Jenny Craig, Medications, Hypnosis, Weight Watchers, ECT.				What is your goal weight? _____ When did you last weigh your goal weight? _____
Weight Loss Method:	Amount of weight loss:	How long did you maintain the weight loss:	Reason for discontinuation:	Indicate ages during which you were overweight: □ age 2-11yrs □ age 12-19yrs □ Age 20–29 yrs □ age 30–40yrs □ over 40yrs
				How much weight do you expect to lose during this program? _____lbs.
				Which weight loss method do you consider your most successful?
				What do you feel made that successful?

PSYCHOSOCIAL HISTORY:

Are you currently undergoing any major lifestyle changes (eg. marriage, divorce, job change, death of someone important to you)? If so, describe: _____

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

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

Why did you choose this particular program? _____

Who do you feel will be supportive of you weight loss and changes in lifestyle?
Spouse Children Roommate(s) Parent(s) Friend(s) Co-worker(s) Other

Who do you feel may **not** be supportive of your weight loss and changes in lifestyle?
Spouse Children Roommate(s) Parent(s) Friend(s) Co-worker(s) Other

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

*Have you ever had suicidal thoughts? □ Yes □ No *Have you ever been severely depressed? □ No □Yes, if so when _____

*Have you ever experienced dramatic mood changes during dieting (especially anxiety or depression)? □ Yes □ No □Possibly

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LIFESYTLE AND EATING HABITS:

Have you ever eaten a large amount of food rapidly and felt this eating incident was excessive and out of control?
□ Yes □ No

If yes, how often did you do this during the past year? (Check one)
□ Less than once a month □ About once a week
□ A few times a month □ A few times a week
□ About once a month □ daily

Have you ever purged (used self – induced vomiting, laxatives, or diuretics)? □ Yes □ No

Do you drink alcohol? □ Yes □ No
If yes, how much? □ 1 drink a month □ 1 drink a week □ a few drinks a week □1 drink daily □ a few drinks daily

On average how many hours do you sleep during a 24-hour period? _____

How often do you exercise? □ Rarely □ Occasionally □ 1-2 times/week □ 3-4 times/week □ 5 or more times a week

Has any doctor or other health care professional ever told you not to exercise? □ Yes □ No
Do you know of any reason why you should not exercise? □ Yes □ No
If yes to either question, please explain: _____

How many meals do you typically eat out per week? _____
Are the majority of these meals with family or friends? □ Yes □ No
Are they usually fast food? (eg. McDonalds, Wawa, Chic Fil A)? □ Yes □ No
Usually in a cafeteria/ restaurant? □ Yes □ No
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 high-fat foods
□ Eating too many sweet foods
□ Eating too quickly
□ Uncontrollable binges
□ Eating in reaction to tension and depression
□ Overeating when alone
□ Using food as a reward
□ Eating to take my mind off other problems
□ Not paying attention to what I'm eating
□ Overeating at social events
□ Lack of satisfaction in life
□ Eating in reaction to boredom
□ Other (explain) _____
_____
_____

I certify that the information on this form is true and correct to the best of my knowledge.

_____ _____
Signature Date

FOR ND USE ONLY