St. Elizabeth PHYSICIANS
Weight Management Center

Welcome to the St. Elizabeth Physicians
Weight Management Center

Thank you for choosing us to help you achieve your weight loss goal!

Enclosed you will find our registration packet, which will help us get to know you better and is the first step in designing a weight loss plan tailored specifically for you. Please complete all information and bring it with you to your appointment.

Directions

- Our Center is located at St. Elizabeth Healthcare Florence.
    1. Please park in the Outpatient area of the hospital in the Zone 3 Lot (Green).
    2. Enter the hospital facility at 3A and enter through the sliding glass doors
    3. Turn left toward the Vascular Institute
    4. We are located just beyond the Vascular Institute at the end of the hallway

Phone: (859) 212-GOAL (4625)

St. Elizabeth PHYSICIANS

PATIENT REGISTRATION / Consent to Treat

Please print the information below and have your insurance card and legal photo ID available for the receptionist to scan.

PATIENT INFORMATION

Social Security # ____-____-_____ Last Name _____ First Name _____ Middle ____

Address_____ City _____ St ____ Zip _____

Home Phone (____)____-_____ Work Phone (___)____-_____ Ext. _____ Email: _____

Date of Birth _____ Marital Status _____ Race _____ Sex ___ Alternate Phone (____)____-_____

Emergency Contact _____ Phone (_____)_____-_____
(Name) (Relationship)

Patient Employer _____ Emp. Address _____ Emp. Phone (___)____-_____

Pharmacy most used by patient _____Pharm. Phone (____) ____-_____

Referring Provider (Specialist office only) _____

PERSON WHO SHOULD RECEIVE THE BILL - RESPONSIBLE PARTY (Guarantor)

Relationship to Patient: Self Parent Spouse Other _____

Social Security # ____-____-_____ Name _____

Address _____ City _____ St ____ Zip_____

Home Phone (____)____-_____ Work Phone (___)____-_____ Ext. _____ Email: _____

Date of Birth _____ Marital Status _____ Race _____ Sex ___ Alternate Phone (____)_____-_____

Employer _____ Emp. Address _____ Emp. Phone (___)____-_____

PRIMARY INSURANCE COMPANY NAME_____ **No Insurance**
(Circle if applicable)

Subscriber Relationship to Patient: Self Parent Spouse Other _____

Subscriber Name: _____ Date of birth _____ SS# ____-___-_____

Employer _____ PCP _____ Copay _____

SECONDARY INSURANCE COMPANY NAME_____

Subscriber Relationship to Patient: Self Parent Spouse Other _____

Subscriber Name: _____ Date of birth _____ SS# ____-___-_____

Employer _____ Copay _____

I understand that I am responsible for payment for all services rendered. I hereby assign, and authorize direct payment of my medical benefits to St. Elizabeth Physicians. However, I understand and agree to pay all charges or amounts not timely paid by my insurance policy or plan including, but not limited to, any co-pays or deductibles. I acknowledge that it is my responsibility to know and understand the terms of my insurance policy or plan. I authorize St. Elizabeth Physicians to release all of my medical and other information to third-party payers, benefit administrators, or other persons as necessary to verify benefits, to authorize medical services to be received, to process claims for benefits, to represent me in a third-party payer's hearing or appeal process, and/or to collect any payments. I permit a copy of this authorization to be used in the place of the original. I authorize the use of "signature on file" to be used on all of my insurance submissions. I understand that I am responsible for notifying the office of any precertification or referral needed for my insurance. In accordance with recognized coding standards, I understand that I may receive separate charges for procedures, physicals and/or other problem-oriented treatment during a single visit.

I further authorize the access and release of my clinical and medication information for treatment by my Primary or Specialty Care Provider and to any and all providers involved in my care.

I give my consent to St. Elizabeth Physicians to provide medical care and treatment to me as deemed necessary and proper by my physician. I authorize St. Elizabeth Physicians billing or my provider's office to contact me by my cell phone. _____YES _____NO

Signature X_____ Date _____
(Signature of patient or patient representative)

Witness _____

St. Elizabeth PHYSICIANS

Receipt of Notice of Privacy Practices
ALTERNATE COMMUNICATION REQUEST FORM

Patient Name _____ Date of Birth _____/_____/_____
(Print full name)

I wish to be contacted in the following manner (check all that apply):

☐ By home, cell or work phone listed in my registration as below.

Home	Cell	Work		Other
☐	☐	☐	O.K. to leave message on voice mail	_____
☐	☐	☐	O.K. to leave message with individual	_____
☐	☐	☐	Leave message with call-back number only	_____
☐	☐	☐	Do not leave message	_____

☐ Written Communication

☐ O.K. to mail to my home address ☐ O.K. to fax to this number _____

☐ O.K. to mail to my work/office address ☐ O.K. to e-mail to address listed in my registration

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I, _____ give permission to the following individuals to obtain the indicated information:
(Name of Patient or Responsible Party)

_____ whose relation to me is _____ Phone (____)_____-_____
(Name of person) (Relationship to Patient)

_____ whose relation to me is _____ Phone (____)_____-_____
(Name of person) (Relationship to Patient)

_____ whose relation to me is _____ Phone (____)_____-_____
(Name of person) (Relationship to Patient)

_____ whose relation to me is _____ Phone (____)_____-_____
(Name of person) (Relationship to Patient)

_____ Prescription refills on my behalf
_____ Test results on my behalf
_____ Set up appointment/ or cancel on my behalf
_____ Speak to the doctor/MA either in person or by telephone on my behalf
_____ Pick up prescriptions, doctor's orders, or other needs on my behalf with a photo ID.

Effective Date _____ Expires _____ Revoked _____

It is the responsibility of the patient to notify the physician's office if there is a change in this information.
*****Scan original in chart, copy may be given to patient*****

By signing this waiver I release St. Elizabeth Physicians and its staff therein, from any liability for release of information pertaining to my medical care as designated above and I acknowledge that I have received a copy of St. Elizabeth Physicians ***Notice of Privacy Practices****. The effective date of the notice is*: 9/23/2013

Signature of patient or responsible person _____

Relationship of Representative to Patient _____ Date _____

Signature of witness _____ Date _____

Health History Questionnaire

Name: _____ Date of Birth: ____/____/____ Age: _____

Present Status

Are you in good health at the present time to the best of your knowledge? No Yes
If no, please explain.

Are you under a doctor's care at the present time? No Yes
If yes, whom and for what?

Are you taking any medications at the present time? No Yes
***Prescription Drugs*: List all**

Drug:	**Dosage:**

***Over-the-Counter medications, vitamins, supplements*: List all**

Product/Dosage	**Product/Dosage**

History of Frequent Headaches or Migraines? No Yes
Medication:_____

Allergies

Are you allergic to latex? No Yes
Are you allergic to medications? No Yes
If yes, please list:

_____ _____
_____ _____
_____ _____

Serious Injuries

Specify (list all including date)

_____ _____

_____ _____

_____ _____

Previous Bariatric Surgery

Type: _____

Date: _____ Surgeon:_____

Original Weight _____ lbs Lowest Weight Achieved _____ lbs

Were there any complications? Please list:_____

_____

_____

Non-Bariatric Surgical History

Specify (list all including date)

_____ _____

_____ _____

_____ _____

Family History

	Age	Health	Disease	Cause of Death	Overweight Y/N
Father					
Mother					
Brothers					
Sisters					

Gynecologic History

Pregnancies: Number: _____ Dates: _____

Natural Delivery or C-Section (specify): _____

Menstrual: Onset _____ **Are they regular:** No Yes

Duration _____ **Pain associated:** No Yes

Last menstrual period: _____ **History of PCOS** No Yes

Hormone Replacement Therapy: No Yes

Type: _____

Birth Control Pills: No Yes

Type: _____

Last Check Up Date: _____

Patient Name:_____ Date of Birth:_____

Medical History

Please check if you or a family member has a history of any of the following conditions:

Condition	Self	Family	Condition	Self	Family
Anemia			Kidney Disease		
Arthritis			Kidney Stones		
Asthma			Liver Disease / Hepatitis		
Blood Clots/ Clotting Difficulty			Malaria		
Previous Blood Transfusions			Measles/ Mumps		
Cancer			Mental Health Issues		
Chicken Pox			Migraine Headaches		
Chronic Cough / Bronchitis			Muscle Weakness or Pain		
Constipation			Nervous Breakdown		
Depression			Osteoporosis		
Diabetes			Pleurisy		
Diarrhea			Pneumonia		
Drug Abuse			Polio		
Eating Disorder			PCOS		
Epilepsy / Seizures			Previous Blood Transfusions		
Gallbladder Disease			Rheumatic Fever		
Glaucoma			Scarlet Fever		
Gout			Sleep Apnea		
Heart Disease			Snoring		
Congestive Heart Failure			Stroke / TIA		
Heart Valve Disorder			Swelling in feet or legs		
Stents			Stomach Problems/ GERD/ Ulcers		
Heart Surgeries			Urinary Incontinence		
Murmur			Tonsillitis		
Arrhythmias (A-fibrillation)			Tuberculosis		
Angina / Chest Pain			Thyroid Problems		
High Blood Pressure			Whooping Cough		
High Cholesterol			Wounds		
			Other		

Please indicate if you have any of the following problems/concerns:

☐ Nausea
☐ Vomiting
☐ Constipation
☐ Diarrhea
☐ Heartburn
☐ Weight loss
☐ Weight gain
☐ Chewing problems
☐ Swallowing problems
☐ Change in appetite
☐ Other_____

Patient Name:_____ Date of Birth:_____

Nutrition History

Gender: _____ Height: _____ Weight: _____ Current Weight: _____
Desired Weight: _____ (What is the weight you would like to be?)
Occupation: _____ Work Schedule: □ Day Shift □ Night Shift
□ Weekdays □ Weekends □ Traveling: _____

Please indicate if you follow a special diet:
Carbohydrate restricted Fat restricted Vegetarian Salt restricted Calorie restricted
Low Cholesterol Other _____

Are you currently following that diet? No Yes (please explain)

_____

If you follow a special diet, who recommended it and why? (i.e. physician, self, friend)

_____

Food Cravings: No Yes (please explain) _____
Any specific time of the day or month that you crave food? _____
Religious or Cultural Food Requests No Yes (please explain) _____

Food Preferences: Do you avoid any food?

_____

Do you have any food allergies? No Yes (please list)

_____

Have you experienced a significant change in weight?" No Yes **If yes, what are your perceived reasons for weight gain or weight loss?**

_____

Have you tried to lose weight before?: No Yes (how many times) _____
If yes, what is the main reason for your decision to lose weight? _____
Do you have a good support system with your weight loss efforts? _____

Body Weight History: Highest Weight _____ When _____
Lowest Weight _____ When _____
Usual Weight _____ When _____
Birth Weight _____ Weight at 20 years old _____

Have you ever tried any of the following for weight control? If yes, did you have success?

Jenny Craig/ Weight Watchers/ Nutrisystem	No	Yes _____	Date _____
Liquid diets (Optifast/Nutrimed/New Direction)	No	Yes _____	Date _____
Meal Replacements (Lean Cuisine, Slim Fast)	No	Yes _____	Date _____
Low carbohydrate (Atkins/South Beach)	No	Yes _____	Date _____
Fad diets	No	Yes _____	Date _____
Prescription diet pills	No	Yes _____	Date _____
Over the counter diet pills	No	Yes _____	Date _____
Laxatives/ Diuretics/ Vomiting	No	Yes _____	Date _____
Excessive exercising	No	Yes _____	Date _____
Self-designed program/ Other	No	Yes _____	Date _____

Comments: _____

Patient Name:_____ Date of Birth:_____

Eating Habits

Do you skip meals? No Yes
How many days per week do you eat: **Breakfast** _____ **Lunch** _____ **Dinner** _____

Please list the times of day and the foods you typically eat at each meal

	Time of Day	Foods Typically Eaten
Breakfast		
Lunch		
Dinner		
Snack		

Do the weekends affect your eating habits? No Yes (please explain)
_____

Do you snack? No Yes If yes, on what types of food do you snack? _____
What time of the day do you snack? _____
Is it a planned snack? No (please explain) _____ Yes

What do you add to your food at the table? Salt Salt substitute Sugar Sugar substitute
Butter Margarine Other _____

Who does the meal planning? Self Significant Other Both Other _____
Who does the grocery shopping? Self Significant Other Both Other _____
What day and what time of the day do you shop? _____
With whom do you live? _____
Is your spouse, fiancée or partner overweight? No Yes If Yes, how much overweight? _____
Who prepares the food at home? Self Significant Other Both Other _____
What is the skill level? _____
Does this person enjoy cooking? _____
Is salt added during cooking? No Yes
Do you eat meals outside of the home? No Yes **How many meals per week?** _____
How many meals per week do you eat out for: breakfast _____ lunch_____ dinner_____
What restaurants do you usually choose? (Please list) 1._____ 2._____
3._____ 4. _____ 5. _____ 6. _____
Do you read food labels? No Yes What do you look at on the label?
_____

Do the nutrition facts on the label influence your decision to eat the food or drink the item?	No	Yes
Do you eat in the car?	No	Yes
Do you eat standing up?	No	Yes
Do you eat while watching TV?	No	Yes
Do you eat while reading or on the computer?	No	Yes
Do you eat with others?	No	Yes
Do you eat fast?	No	Yes
Do you eat when bored?	No	Yes
Do you eat when stressed?	No	Yes
Do you eat when you are anxious?	No	Yes
Do you eat when you are lonely?	No	Yes
Do you eat when you are hungry?	No	Yes
Do you eat when you are <u>not</u> hungry?	No	Yes
Do you awaken hungry during the night?	No	Yes (If yes, what do you do? _____)

Patient Name:_____ Date of Birth:_____

Do you think that you are currently undergoing a stressful situation or an emotional upset?
No Yes If yes, please explain _____

Are there some foods you find it impossible to stop eating once you start? No Yes
Do you tend to clean your plate even if you are full before the meal is over? No Yes
Do you use food as a reward or to get energy when you feel tired? No Yes
Do you gulp or inhale your food so that you barely taste it? No Yes
Do you feel that sometimes your eating is sometimes out of control and you can't seem to change it? No Yes
If you are on a diet and eat a food that is not allowed, will you eat more or less for the rest of the day More Less
Do you feel that you eat significantly less than others do and still gain weight? No Yes
Is income a factor in your selection of food? No Yes

What types of beverages do you usually drink? How many servings of each do you drink in a day?

Beverage Type	**Number of servings per day**
Water	
Juice: (please check) regular juice diet juice	
Soda: (please check) regular soda diet soda caffeine free soda	
Iced tea: (please check) sweet tea diet tea green tea caffeine free tea	
Milk:(please check) whole milk 2 % milk 1% milk skim milk	
Coffee: (please check) regular decaffeinated cappuccino non-dairy creamer half and half sugar	
Alcohol: (please check) beer wine hard liquor	

Please list any specific questions or concerns that you may have regarding nutrition:
_____
_____
_____

What, if any, expectations do you have coming to see the dietitian here?
_____
_____
_____

Smoking Habits

Answer only one:

You have never smoked cigarettes, cigars or a pipe.
You quit smoking ____years ago and have not smoked since.
You have quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling smoke.
You smoke 20 cigarettes per day (1 pack).
You smoke 30 cigarettes per day (1-1/2 packs).
You smoke 40 cigarettes per day (2 packs).

Patient Name:_____ Date of Birth:_____

Activity Level

Answer only one:

Inactive—no regular physical activity with a sit-down job.
Light activity—no organized physical activity during leisure time.
Moderate activity—occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
Heavy activity—consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week..
Vigorous activity—participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

Behavior Style

You are always calm and easygoing.
You are usually calm and easygoing.
You are sometimes calm with frequent impatience.
You are seldom calm and persistently driving for advancement.
You are never calm and have overwhelming ambition.
You are hard-driving and can never relax.

Please describe your general health goals and improvements you wish to make:

Functional/Educational/Psychosocial History

Are you able to read and write? No Yes
What is your highest level of education? _____
How do you learn best? Reading Watching Talking Practicing
Do you have any limitations to learning? No Yes
If yes please explain: _____
Do you have a learning disability? No Yes
If yes please explain: _____
Do you speak and understand English? No Yes
If no, what is you primary language? _____
Do you have any hearing loss? No Yes
If yes please explain: _____
Do you have any vision loss? No Yes
If yes please explain: _____
Do you have any speech limitations? No Yes
If yes please explain: _____
Do you have any physical limitations? No Yes
If yes, what limitations do you have? _____
Are you able to get in/out of a chair/bed? No Yes
Do you have any special religious/cultural needs? No Yes
Are you able to perform the activities of daily living? No Yes

Pain Assessment

Are you having pain now or have you experienced pain in the recent past several weeks? ☐ No ☐ Yes
If you answered yes above, will your pain interfere with your visit today? ☐ No ☐ Yes
Can we assist you with your pain with a list of community resources? ☐ No ☐ Yes
Resource list given? ☐ No ☐ Yes

This information will assist us in assessing your particular problem areas and establishing your medical management.
Thank you for your time and patience in completing this form.

Patient Name:_____ Date of Birth:_____

Food and Activity Log Instructions:
PLEASE COMPLETE 4 DAYS OF TRACKING

Meal or Snack: Indicate the type of eating with the appropriate letter, either M for meal or S for snack.

Time spent eating: Record the amount of time spent eating the meal or snack.

Starting time: Include the time the meal or snack began.

Food eaten and how it was prepared: If space allows, include cooking method, added fats, oils, or sugar, and condiments. Please indicate the cut of meat if possible.

Amount eaten: Estimate the amount of food eaten. If you can, indicate the amount in teaspoons, tablespoons, cups, ounces, or pounds, but if you don't know these, try to compare the size of the food portion to a common household item such as a light bulb or a deck of cards.

Hunger: On a scale of 0 to 5, rate how hungry you were when you ate the meal or snack, with 0 being "not hungry" and 5 being "extremely hungry".

Reason/Mood: Note your mood and the emotional reasons which may have caused you to eat. If there are none, write "none".

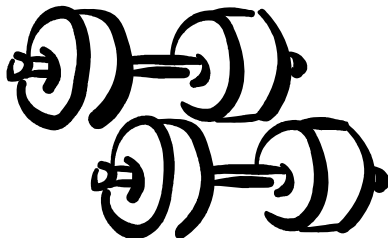
Location: Where were you when you ate? If you were at home, what room were you in? Were you on the couch? In bed?

Eating position: Indicate whether you were 1 – walking, 2- standing, 3 – sitting, or 4 – lying down.

With whom: Were you eating with anyone else? Whom?

Doing what: Were you doing something else while you ate such as checking Email, watching TV, or reading a book?

Type of exercise and how long: Record daily exercise as specifically as possible. "Walked over 1 mile of flat ground at a moderate pace" is more specific than "Took a walk"



Patient Food and Activity Log

Name _____ Date_____

Meal or Snack? Time spent eating Starting time	Food eaten and how it was prepared, including condiments	Amount eaten	Hunger 0 = none 5= very	Reason/ Mood	Location, Eating position, With whom, Doing what	Type of exercise and how long
Example M, 15 minutes, 6:45 AM	*Quaker oats prepared with 1% milk and 1 t brown sugar, OJ, banana*	*¾ cup oat. 1 c OJ Med banana*	*4*	*Hungry*	*Kitchen, 2 and 3, alone, packing lunch*	