

Thank you for choosing St. Elizabeth to support your weight loss journey! To ensure we can create a personalized program tailored to your needs, **it is required that you complete the new patient packet prior to your first appointment.** If you return the packet via email or fax, please allow the office at least two business days to contact you regarding scheduling.

### Checklist and survey for your initial visit at the Weight Management Center

- Did you complete a patient information session? (Initial and enter date of participation)  
\_\_\_\_\_ Watched online session by weight management physician Date viewed: \_\_\_\_\_

If you have not participated in an online session, please note that this free education is required prior to your first visit. It allows us to provide essential information to you without charging you for an extensive office visit.

- After learning about the options during the information session, which program do you feel is right for you? (Initial your choice below)
- \_\_\_\_\_ Very Low-Calorie Diet (VLCD): meal replacement only program.
  - \_\_\_\_\_ Outlook One: 1 meal and 2+ meal replacements.
  - \_\_\_\_\_ Outlook Two: 2 meals and 1+ meal replacements.
  - \_\_\_\_\_ Outlook Three: All food (no meal replacements).

- I understand the financial and follow-up requirements of the program:
- Weekly follow-up initially.
    - If not covered by insurance, \$39 self-pay charge for dietician visit will apply.
  - Meal replacements are approximately \$3.50 per replacement.
  - If this is not affordable, please discuss it with your provider at the initial visit.

- I understand that I will not start the program the day of my initial visit.
- VLCD: Program start will be a one-on-one visit with the nurse practitioner.
  - LCD: Program start will be after a New Start LCD Class with a dietitian.

Information required when scheduling your first appointment:

- \_\_\_\_\_ This checklist.
- \_\_\_\_\_ Copy of your insurance card
- \_\_\_\_\_ Completed Weight Management Center New Patient Packet (Including the 4-day food log)
  - Mailed to you, or sent through Mychart by our staff
  - Printed from [www.stedocs.com/MedicalWeightLossNewPatient](http://www.stedocs.com/MedicalWeightLossNewPatient)
- \_\_\_\_\_ Call your insurance to verify benefits for Registered Dietitian visits.

If you have further questions prior to your visit, please contact us at (859)212-GOAL (4625).

Dear Valued Patient,

It is with great pleasure that we welcome you to the St. Elizabeth Physicians Weight Management Center. On behalf of our entire weight management team of professionals, we thank you for choosing us and look forward to partnering with you on your weight loss journey.

My name is Dr. Troy Schumann. I have been in family practice for many years in Northern Kentucky and I am the medical director for the weight management center. I, along with Dr. Lori Catanzaro, Dr. Jennifer Paisley, and Nurse Practitioner Heather Schuler, are available to help you succeed in your weight loss journey.

It is our mission to provide an evidence-based approach to weight loss and customize an individualized treatment plan for you. We work closely with our experienced, specialized staff of dietitians, behavioral health professionals, nurses, and fitness professionals to ensure optimal patient care, safety, and outcomes.

To expedite your appointment, we have enclosed a health questionnaire and other patient documents that will provide us with vital information. We require you to complete this entire packet and return it to our office prior to scheduling your first appointment. This will provide the information we need to create a personalized weight management solution for you.

Out of respect for all our patients, providers and associates we require at least a 24-hour notice to cancel or change an appointment. If you have any questions, please feel free to call us at (859) 212-GOAL (4625).

Thank you for your trust in us. We look forward to collaborating with you on this important decision you've made to live a healthier life.

Sincerely,

Dr. Troy Schumann, Medical Director  
Dr. Lori Catanzaro, Bariatrician  
Dr. Jennifer Paisley, Bariatrician  
Heather Schuler, APRN

**St. Elizabeth Physicians Weight Management Center  
Locations and Directions**

**Florence, Kentucky**

1. Located at 4900 Houston Road, Florence Kentucky, 41042.
2. Park in the Outpatient area of the hospital in Zone 3A (green).
3. Enter the hospital at the 3A entrance, through the sliding glass doors.
4. Turn left near patient registration, then another left past the restrooms.
5. We are located at the end of the hallway on the right.

**Ft. Thomas, Kentucky**

1. Located at 1400 North Grand Avenue, Fort Thomas, Kentucky, 41071.
2. Turn right at the traffic light to the St. Elizabeth Medical Pavillion.
3. Park in the outpatient parking lot in front of the building.
4. Go to the main entrance and enter through the sliding glass doors.
5. Turn left toward Heart and Vascular and continue down the hall to Weight Management. The reception desk is on the right side of the hallway.

**Greendale, Indiana – This location is only open Wednesday and Thursday**

1. Located at 1640 Flossie Drive, Greendale, Indiana, 47025.
2. Take I-275 West or East towards Lawrenceburg Aurora Exit. #16.
3. Turn right off the exit ramp on Route 50.
4. Turn right into Greendale Plaza Drive, then another right onto Flossie Drive.
5. Park in the outpatient lot in front of the building, enter the main entrance through the sliding glass doors.
6. The reception desk is at the main entrance.

**Returning your completed packet: Choose one of the following**

**Fax:** 859-212-4638 (Florence)  
859-441-1460 (Ft. Thomas/Greendale)

**Email:** [122957@stelizabeth.com](mailto:122957@stelizabeth.com) (Florence)  
[107873@stelizabeth.com](mailto:107873@stelizabeth.com) (Ft. Thomas/Greendale)

**Mail:** SEP Weight Management Center, 4900 Houston Rd, Florence, KY 41042  
SEP Weight Management Center, 1400 N. Grand Ave., Newport, KY 41075

**You may also return your completed packet to any of our locations, please note open availability above.**

**Phone: (859) 212-GOAL (4625)**

### 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 not, please explain:

\_\_\_\_\_

\_\_\_\_\_

Are you under the care of a physician at the present time?  No  Yes  
If yes, whom and for what condition?

\_\_\_\_\_

Are you taking any medications at the present time?  No  Yes  
If yes, please list all prescription medications below:

Drug Name:	Dosage:

Over-the-counter medications, vitamins, and supplements: List all

Drug Name:	Dosage:

History of Frequent Headaches or Migraines?  No  Yes  
Medication: \_\_\_\_\_

Are you allergic to latex?  No  Yes

Are you allergic to medications?  No  Yes

If yes, please list:

\_\_\_\_\_

**Serious Injuries Serious Injuries**

Specify all serious injuries and include date:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Previous Bariatric Surgery**

Type: \_\_\_\_\_ Date: \_\_\_\_\_ Surgeon: \_\_\_\_\_  
 Original Weight: \_\_\_\_\_ lbs. Lowest Weight Achieved: \_\_\_\_\_ lbs.

Were there any complications? Please List:

\_\_\_\_\_  
 \_\_\_\_\_

**Non- Bariatric Surgical History**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Family History**

Relationship	Age	Health (Good, Poor)	Disease(s)	Cause of Death	Overweight Yes/No
Father					
Mother					
Brothers					
Sisters					

**Gynecologic History**

Number of Pregnancies: \_\_\_\_\_ Number of Deliveries: \_\_\_\_\_ Dates: \_\_\_\_\_

Vaginal Delivery or Cesarean Delivery (specify): \_\_\_\_\_

Menstrual History:

Age of onset: \_\_\_\_\_

Duration in days: \_\_\_\_\_

Last menstrual period: \_\_\_\_\_

Hormone replacement therapy:  No  Yes

Do you take birth control pills?  No  Yes

Are your periods regular?  No  Yes

Do you have pain associated:  No  Yes

History of PCOS?  No  Yes

Last Annual Well Woman exam? \_\_\_\_\_

If yes, name of birth control: \_\_\_\_\_

### Medical History

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

Condition	Self	Family Member	Condition	Self	Family Member
Anemia			Nervous Breakdown		
Angina/Chest Pain			Osteoporosis		
Arrhythmia (A-Fib)			PCOS		
Arthritis			Pleurisy		
Asthma			Pneumonia		
Blood clots/Clotting difficulty			Polio		
Cancer			Previous Blood Transfusion		
Change in appetite			Rheumatic Fever		
Chewing problems			Scarlet Fever		
Chicken Pox			Sleep Apnea		
Chronic Cough			Snoring		
Congestive Heart Failure			Stents		
Constipation			Stomach Issues		
Depression			Stroke/TIA		
Diabetes			Swallowing Problems		
Diarrhea			Swelling in feet/legs		
Drug Abuse			Thyroid Problems		
Eating Disorder			Tonsillitis		
Epilepsy / Seizures			Tuberculosis		
Gallbladder Disease/removal			Urinary Incontinence		
Glaucoma			Vascular Disease (Carotid, AAA, PAD)		
Gout			Weight Gain		
Heart Disease			Weight Loss		
Heart Murmur			Whooping Cough		
Heart Surgeries			Wounds		
Heart Valve Disorder			Other:		
Heartburn/GERD					
High Blood Pressure					
High Cholesterol					
Kidney Disease					
Liver Disease / Hepatitis					
Malaria					
Measles/Mumps					
Mental Health Issues					
Migraine Headaches					
Muscle Weakness					
Nausea					

### Nutrition History

Gender: \_\_\_\_\_ Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_ Desired Weight: \_\_\_\_\_ (What would you like it to be?)  
 Occupation: \_\_\_\_\_ Work Schedule:  Day Shift  Night Shift  
 Weekdays  Weekends  Traveling Required: \_\_\_\_\_

Please indicate if you follow a special diet:  
 Carbohydrate restricted  Fat restricted  Vegetarian  Salt/sodium restricted  Calorie Restricted  
 Low Cholesterol  Other: \_\_\_\_\_

Are you currently following that diet?  No  Yes If no, please explain: \_\_\_\_\_

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

Food Cravings:  No  Yes If yes, please explain: \_\_\_\_\_  
 Any specific time of day or month that you crave food? \_\_\_\_\_  
 Religious or Cultural Food Requests: \_\_\_\_\_  
 Food Preferences: Do you avoid any foods? \_\_\_\_\_  
 Do you have any food allergies?  No  Yes If yes, please explain: \_\_\_\_\_  
 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 for 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?

Program or diet type	Tried?	Success?	Date
Jenny Craig / Weight Watchers / Nutrisystem	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Liquid diets (Optifast / NutriMed / New Direction)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Meal Replacements (Lean Cuisine / Slim fast)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Low carbohydrate (Atkins / South Beach)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Fad Diets	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Prescription diet pills	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Over-the-counter diet pills	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Laxatives/Diuretics / Vomiting	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Excessive Exercising	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Self-designed program / other	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	

**Eating Habits Eating Habits**

Do you skip meals?  No  Yes How many days per week do you eat the following meals?  
 Breakfast \_\_\_\_\_ Lunch \_\_\_\_\_ Dinner \_\_\_\_\_

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

Meal	Time of Day	Foods Typically Eaten
Breakfast		
Lunch		
Dinner		
Snacks		

Do the weekends affect your eating habits?  No  Yes If yes, please explain: \_\_\_\_\_

Do you snack?  No  Yes If yes, on what types of food? \_\_\_\_\_

What time of day do you snack? \_\_\_\_\_

Is it a planned snack?  No  Yes If no, please explain: \_\_\_\_\_

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 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 significant other 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?  No  Yes  Unknown

Is salt added to food while cooking?  No  Yes  Unknown

Do you eat meals outside of your home?  No  Yes If yes, how many meals per week? \_\_\_\_\_

How many meals per week do you eat 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 If yes, what do you look at on the label? \_\_\_\_\_

Do nutritional facts influence your decision to eat or drink the food?  No  Yes

Do you eat in the car?  No  Yes Do you eat when bored?  No  Yes

Do you eat standing up?  No  Yes Do you eat when stressed?  No  Yes

Do you eat while watching TV/while using social media/internet?  No  Yes Do you eat when anxious?  No  Yes

Do you eat while reading or on the computer? Do you eat when lonely?  No  Yes

Do you eat with others?  No  Yes Do you eat when hungry?  No  Yes

Do you eat fast?  No  Yes Do you eat when you are **not** hungry?

Do you wake up hungry during the night?  Yes

N

If yes, what did you do? \_\_\_\_\_

**Eating Habits (continued)**

Do you think that you are currently undergoing a stressful situation or are emotionally upset?  No  Yes

If yes, please explain: \_\_\_\_\_

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

**Beverage Consumption**

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

Beverage Type	Number of servings per day
<input type="checkbox"/> Water	
<input type="checkbox"/> Juice (please check) <input type="checkbox"/> Regular <input type="checkbox"/> Diet	
<input type="checkbox"/> Soda (please check) <input type="checkbox"/> Regular soda <input type="checkbox"/> Diet <input type="checkbox"/> Caffeine Free	
<input type="checkbox"/> Iced Tea (please check) <input type="checkbox"/> Sweet tea <input type="checkbox"/> Diet tea <input type="checkbox"/> Green <input type="checkbox"/> Caffeine Free	
<input type="checkbox"/> Milk (please check) <input type="checkbox"/> Whole Milk <input type="checkbox"/> 2% Milk <input type="checkbox"/> 1% Milk <input type="checkbox"/> Skim Milk	
<input type="checkbox"/> Coffee (please check) <input type="checkbox"/> Regular <input type="checkbox"/> Decaffeinated <input type="checkbox"/> Cappuccino	
<input type="checkbox"/> Non-dairy creamer <input type="checkbox"/> half & half <input type="checkbox"/> Sugar	
<input type="checkbox"/> Alcohol (please check) <input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor/Mixed Drinks	

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

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What expectations do you have coming to see the dietitian here?

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**Smoking Habits**

Answer only one:

- You have never smoked cigarettes, cigars, pipe tobacco, or vape pens
- You quit smoking or vaping \_\_\_\_ years ago and have not smoked since
- You quit smoking at least a year ago and now smoke cigars, pipe tobacco or use a vape pen
- You smoke 20 cigarettes per day (1 pack)
- You smoke 30 cigarettes per day (1½ packs)
- You smoke 40 cigarettes per day (2 pack)

**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 –occasional physical activity (i.e., 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**

Answer only one:

- You are always calm and easygoing.
- You are usually calm and easygoing.
- You are sometimes calm and frequently impatient.
- You are seldom calm and persistently driving for advancement
- You are never calm and have overwhelming ambition.
- You are hard-driven and can never relax.

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

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**Functional/Educational/Psychological 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: \_\_\_\_\_

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Do you have a learning disability?  No  Yes If yes, please explain: \_\_\_\_\_

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What is your primary language (reading / speaking)? \_\_\_\_\_

Do you have any hearing loss?  No  Yes If yes, please explain: \_\_\_\_\_

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Do you have any vision loss?  No  Yes If yes, please explain: \_\_\_\_\_

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Do you have any speech limitations?  No  Yes If yes, please explain: \_\_\_\_\_

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Do you have any physical limitations?  No  Yes If yes, please explain: \_\_\_\_\_

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Are you able to get in and out of a chair/bed?  No  Yes

Do you have any special religious or cultural needs?  No  Yes

Are you able to perform the activities of daily living?  No  Yes

**Pain Assessment**

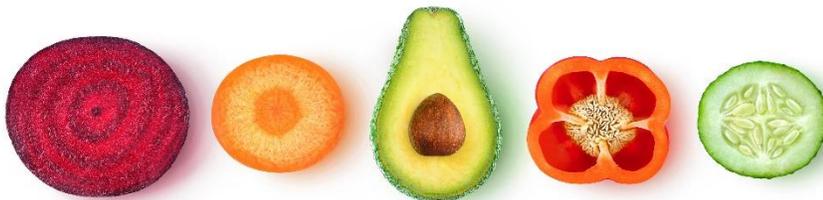
Are you having pain now or have you experienced pain in the recent past several weeks?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If you answered yes above, will your pain interfere with your visit today?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can we assist you with your pain with a list of community resources?	<input type="checkbox"/> No <input type="checkbox"/> Yes

This information will assist us in assessing your personal needs and establishing your medical management. Thank you for taking time to complete this form in its entirety.

**Food and Activity Log Instructions**

**Please complete 4 days of tracking**

- Meal or snack: Indicate the type of eating with the appropriate letter; M for meals and S for snacks.
- Time spent eating record the amount of time spent eating the meal or snack.
- Starting time: Include the time the meal or snack begins.
- 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 do not 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 the 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
  4. Lying down
- With whom: Were you eating with anyone else? Whom?
- Doing what: Were you doing something else while you ate such as email, watching TV, videos, 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”.



**Food and Activity Log**

Meal or Snack	Food eaten & how it was prepared including condiments	Amount Eaten	Hunger Scale 0-5	Reason/Mood	Location, eating position, with whom & doing what	Type of exercise & how long
Example: M, 15 min. 6:45	Oats prepared with 1% milk, 1t brown sugar, OJ, Banana	¾ cup oat 1c OJ Med banana	4	Hungry	Kitchen, 2 and 3, alone, packing lunch	Walking, flat, slow pace 20 min

### Food and Activity Log

Meal or Snack	Food eaten & how it was prepared including condiments	Amount Eaten	Hunger Scale 0-5	Reason/Mood	Location, eating position, with whom & doing what	Type of exercise & how long
Example: M, 15 min. 6:45	Oats prepared with 1% milk, 1t brown sugar, OJ, Banana	$\frac{3}{4}$ cup oat 1c OJ Med banana	4	Hungry	Kitchen, 2 and 3, alone, packing lunch	Walking, flat, slow pace 20 min

### Patient Health Questionnaire

This questionnaire is an important part of providing you with the best healthcare possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip over a question.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Today's date: \_\_\_\_\_

1. During the last 4 weeks, how much have you been bothered by any of the following problems	Not bothered	Bothered a little	Bothered a lot
a. Stomach pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Back pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Pain in your arms, legs, or joints (knees, hips, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Menstrual cramps or other problems with your periods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Pain or problems during sexual intercourse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Chest Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Dizziness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Fainting spells	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Feeling your heart pound or race	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Shortness of breath	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. Constipation, loose bowels, or diarrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m. Nausea, gas, or indigestion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. During the last 2 weeks, how much have you been bothered by any of the following problems	Not at all	Some days	More than half the days	Nearly everyday
a. Little interest or pleasure in doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Feeling down, depressed, or hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Trouble falling or staying asleep or sleeping too much	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Feeling tired or having little energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Poor appetite or overeating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Trouble concentrating on things, such as reading a book or watching television.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Moving or speaking so slowly that other people could have noticed? Or the opposite being so fidgety or restless that you have been moving around a lot more than usual.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

PHQ1/3

**Patient Health Questionnaire (continued)**

3. Questions about anxiety	No	Yes
a. In the last 4 weeks, have you had an anxiety attack, suddenly feeling fear or panic? IF YOU CHECKED NO, GO TO QUESTION #5	<input type="radio"/>	<input type="radio"/>
b. Has this ever happened before?	<input type="radio"/>	<input type="radio"/>
c. Do some of these attacks come suddenly out of the blue, that is, in situations where you do not expect to be nervous or uncomfortable?	<input type="radio"/>	<input type="radio"/>
d. Do these attacks bother you a lot or are you worried about having another attack?	<input type="radio"/>	<input type="radio"/>

4. Questions about anxiety	No	Yes
a. Were you short of breath	<input type="radio"/>	<input type="radio"/>
b. Did your heart race, pound or skip	<input type="radio"/>	<input type="radio"/>
c. Did you have chest pain or pressure	<input type="radio"/>	<input type="radio"/>
d. Did you sweat	<input type="radio"/>	<input type="radio"/>
e. Did you feel as if you were choking	<input type="radio"/>	<input type="radio"/>
f. Did you have hot flashes or chills	<input type="radio"/>	<input type="radio"/>
g. Did you have nausea or an upset stomach or the feeling that you were going to have diarrhea	<input type="radio"/>	<input type="radio"/>
h. Did you feel dizzy , unsteady, or faint	<input type="radio"/>	<input type="radio"/>
i. Did you have tingling or numbness in parts of your body	<input type="radio"/>	<input type="radio"/>
j. Did you tremble or shake	<input type="radio"/>	<input type="radio"/>
k. Were you afraid you were dying	<input type="radio"/>	<input type="radio"/>

5. Over the last 4 weeks, how often have you been bothered by any of the following problems?	Not at all	Some days	More than half the days
a. Feeling nervous, anxious, on edge, or worrying a lot about different things. IF YOU CHECKED "NOT AT ALL," GO TO QUESTION #6	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Feeling restless so that it is hard to sit still	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Getting tired very easily	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Muscle tension, aches, or soreness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Trouble falling asleep or staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Trouble concentrating on things such as reading a book or watching TV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Becoming easily annoyed or irritable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Patient Health Questionnaire (continued)**

6. Questions about eating	No	Yes
a. Do you often feel that you can't control what or how much you eat	<input type="radio"/>	<input type="radio"/>
b. Do you often eat within any 2-hour period, what people would regard as an unusually large amount of food?	<input type="radio"/>	<input type="radio"/>
c. Has this been as often, on average, as twice a week for the last 3 months	<input type="radio"/>	<input type="radio"/>

7. In the last 3 months have you often done any of the following to avoid gaining weight?	No	Yes
a. Make yourself vomit	<input type="radio"/>	<input type="radio"/>
b. Take more than twice the recommended dose of laxatives	<input type="radio"/>	<input type="radio"/>
c. Fasted- not eaten anything at all for at least 24 hours	<input type="radio"/>	<input type="radio"/>
d. Exercised for more than an hour specifically to avoid gaining weight after binge eating	<input type="radio"/>	<input type="radio"/>

8. If you checked "Yes" to any of these ways of avoiding gaining weight, were any as often on average as twice a week?	No <input type="radio"/>	Yes <input type="radio"/>
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9. Do you ever drink alcohol (including beer or wine)?	No	Yes
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10. Have any of the following happened to you more than once in the last 6 months?	No	Yes
a. You drink alcohol even though a doctor suggested that you stop drinking because of a problem with your health	<input type="radio"/>	<input type="radio"/>
b. You drink alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities	<input type="radio"/>	<input type="radio"/>
c. You missed or were late for work, school, or other activities because you were drinking or hung over	<input type="radio"/>	<input type="radio"/>
d. You had a problem getting along with other people while you were drinking	<input type="radio"/>	<input type="radio"/>
e. You drove a car after having several drinks or after drinking too much	<input type="radio"/>	<input type="radio"/>

11. If you checked off any problems on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	Not at all difficult <input type="radio"/>	Somewhat difficult <input type="radio"/>	Very difficult <input type="radio"/>	Extremely difficult <input type="radio"/>
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### Insurance Benefit Verification for Registered Dietician Visits

Prior to your first visit with the Registered Dietician at the Weight Management Center, please contact your insurance company to determine if your plan covers charges for this service. This will help you determine what your cost will be while in the medical weight management program. During the first month of your weight management program, you will be with the registered dieticians once a week.

Use the space below to make clear notes of your conversation with your insurance company and return it to our office. You will specifically verify coverage for the following codes:

Office visit code 97802 and 97803 using a primary diagnosis of

- Overweight (E66.3)
- Obesity (E66.9, E66.0, E66.09, E66.8)
- Obesity, extreme or morbid (E66.01)

And a secondary diagnosis of

- Dietary Surveillance and Counseling (Z71.3)

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Insurance Company: \_\_\_\_\_

Date and time of call: \_\_\_\_\_

Name of Representative: \_\_\_\_\_

Does your insurance plan cover Medical Nutrition Therapy visits with a registered dietician in a medically supervised weight loss program? YES or NO

How many visits, or hours, are covered per year? \_\_\_\_\_

\*\* Patients with Medicaid - Registered Dieticians are NOT credentialed with Medicaid and are not a covered service.

\*\*Patients with Medicare or Medicare Advantage Plans – coverage is only available for the treatment of diabetes and/or chronic kidney disease. An ABN must be signed for every RD visit.

\*\*The self-pay rates for one-on-one sessions are \$82 for 1 hour and \$39 for 30 minutes. Payment will be collected at the time of service, or we will have to reschedule your appointment. We also offer group classes led by our Nurse Practitioner, along with one of our Dietitians. This service is typically covered by Medicaid.

\*\*Patients will not receive a body comp if they are pregnant or have a pacemaker, spinal cord stimulator, bladder stimulator, insulin pump etc. unless able to turn the device off.

**Medical Weight Loss Program New Start Class Schedule**

<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
<b>12:00 pm</b> <b>Virtual</b> <b>LCD New Start Class</b>		<b>4:30 pm</b> <b>In-person</b> <b>LCD New Start Class</b>	<b>5:00 pm</b> <b>Virtual</b> <b>LCD New Start Class</b>	

### Medical Weight Loss Program Costs

St. Elizabeth Weight Management Center’s Medical Weight Loss Programs are physician-supervised, professionally staffed by a team of specialists and evidence-based to ensure that you have the tools you need to be successful long-term in a safe and supportive environment.

Consider the emotional and monetary investment that you have made with past diet attempts. Now consider the value of this as an investment in a healthier future for yourself. Consider you may significantly reduce your monthly costs of medications and medical care when you improve chronic health conditions and reduce or eliminate the need for medications for diseases such as hypertension, diabetes, and high cholesterol.

Actual charges for services and products as part of your weight loss plan may vary as plans are individualized for our patients. However, normal charges are listed on the following page for general reference.

### Medical Weight Loss Programs

Fee Schedule	Billed Charges	Discounted Self Pay Price
Initial Physician Visit	\$175-\$409	\$123-\$286
Follow-up Physician Visit	\$137-\$313	\$96-\$219
Initial Dietician Assessment	\$196	\$82
Initial Behavioral Health Assessment	\$434	\$304
Follow-up Dietician Visits	\$84	\$39

### Non-Billable Program Charges

New Direction® Meal Replacements	Box of 7 packets	\$25 per box
i.e., 600 calories/day =	3 packets or 3 boxes per week	\$75 per week in product costs
i.e., 800 calories/day =	4 packets or 4 boxes per week	\$100 per week in product costs

### Lab/EKG Fees Baseline Testing:

Test	Fee	Test	Fee
CBC with differential	\$34.14	HgA1c	\$46.34
CMP	\$40.15	Fasting Insulin	\$54.57
TSH	\$80.26	Uric Acid	\$21.56
T3	\$80.89	Magnesium	\$31.99
T4	\$43.05	Vitamin D	\$183.86
Lipid Panel	\$54.36	Blood Draw (venipuncture) fee	\$10.50
Urinalysis	\$15.12		

**\*\*All prices are subject to change\*\***

## Attendance Policy

Patients are required to attend to meet attendance expectations set by their provider throughout the program.

- Patients must attend their weekly prescribed visit or class during the “reducing” and “adapting” phases.
- Patients are expected to ARRIVE at the time instructed for that specific visit or class which is typically 20-30 minutes prior to the actual appointment/class time to complete check-in processes. This is critical in order for patients to be ready for the provider to see them at their scheduled appointment time. Medical intake/measurements are done during this time.
- Patients arriving more than 5 minutes past the instructed ARRIVAL time may be asked to reschedule a make-up session.
- During the “reducing” and “adapting” phases, patients will be allowed to miss no more than three weekly visits in four months. A patient missing more than this may be dismissed from the program as close supervision is an essential element of the program's structure.
- At least 24-hour advanced notice must be given to the Weight Management Center if a patient must cancel or change their scheduled visit/class. Rescheduling will be subject to the provider’s availability. Dismissal from the practice may occur if a patient misses 3 appointments without giving proper 24 hour+ advanced notice.
- Patients should notify appropriate clinical staff at least two weeks prior to vacation so that arrangements can be made for appropriate counseling and product supply and to cancel any appointments they will not be attending. Patients can request a one-time leave of absence if situations arise that may prohibit them from attending appointments for a prolonged period of time.

On behalf of the St. Elizabeth Physicians Weight Management Center team, thank you for your time today. We are looking forward to building a life-long partnership to assist you on your journey to a healthier weight and lifestyle. If you have further questions or would like to schedule an appointment, please contact us at (859) 212-GOAL (4625).

## Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

**English:** St. Elizabeth Physicians provides language assistance services and appropriate auxiliary aids, including electronic and written translated documents and oral interpretation, free of charge and in a timely manner, when such services are needed to provide meaningful access to an individual with limited English proficiency.

**Arabic:** St. Elizabeth Physicians تقدم مستشفي خدمات المساعدة اللغوية ووسائل الإعانة المناسبة، بما في ذلك خدمات ترجمة الوثائق الإلكترونية والمكتوبة وخدمات الترجمة الفورية الشفهية، مجاناً وفي الوقت المناسب، عند الحاجة إلى مثل هذه الخدمات لتوفير إمكانية الوصول المجدية للأفراد ذوي إجادة محدودة في اللغة الإنجليزية.

**Burmese:** St. Elizabeth Physicians သည် အင်္ဂလိပ်ဘာသာစကားကျွမ်းကျင်မှုအားနည်းသော ပုဂ္ဂိုလ်အား အပြည့်အဝ ဝန်ဆောင်မှုရယူသုံးစွဲခွင့် ပံ့ပိုးပေးရာတွင် ဘာသာစကားအကူအညီဝန်ဆောင်မှုများကိုသာမက ဘာသာပြန်ဆိုထားသော အီလက်ထရောနစ်နှင့် လက်ရေးစာရွက်စာတမ်းများ၊ နှုတ်ဖြင့် စကားပြန်များအပါအဝင် သင့်လျော်သည့် အထောက်အကူပြု ဝန်ဆောင်မှုများကို လိုအပ်ပါက အချိန်နှင့်တစ်ပြေးညီ အခမဲ့ ပံ့ပိုးပေးသည်။

**Chinese:** St. Elizabeth Physicians 提供免费且及时的语言援助服务和适当的辅助设备 · 包括书面翻译电子文件和口译服务 · 以便与英语能力有限人士进行有效沟通 ·

**Oromo:** St. Elizabeth Physicians tajaajila gargaarsa afaanii fi deeggarsa meeshaalee dhageettii, dubbii fi arguu barbaachisoo ta’an, sanadoota elektirooniksii fi barreeffamaan hiikamanii fi turjumaana afaanii dabalatee, kaffaltii malee fi yerootti tajaajilli akkasii barbaachisutti, nama dandeettii Ingiliffaa murtaa’aa qabu tokkoof dhaqqabamummaa hiika qabu ni kenna.

**Dutch:** St. Elizabeth Physicians biedt gratis en tijdig taalondersteuning en passende hulp, waaronder elektronische en schriftelijke vertaling van documenten en een tolk, wanneer dergelijke diensten nodig zijn om de toegankelijkheid tot de zorg te verbeteren voor personen met een beperkte Engelse taalvaardigheid.

**Pennsylvania Dutch:** St. Elizabeth Physicians duitt Lei helfe as Druwwel hen fer Englisch verschteh. Sell meent, sie kenne em Copies uff der Computer odder uff Babier griege vun Documents in Englisch as in differnti Schprooche getranslate sin. Sie kenne aa en Interpreter beigriegen wammer Hilf braucht fer schwetze mit ebber in Englisch. Des alles duhn sie unni as es em ennich ebbes koscht, un gschwind.

**French:** St. Elizabeth Physicians fournit des services d’assistance linguistique et des aides auxiliaires appropriées, y compris des documents électroniques et écrits traduits et une interprétation orale, gratuitement et en temps opportun, lorsque ces services sont nécessaires pour fournir un accès important à une personne dont la maîtrise de l’anglais est limitée.

**German:** St. Elizabeth Physicians bietet kostenlos und zeitnah Sprachmittlungsdienste und entsprechende Hilfsmittel an, wie die schriftliche Übersetzung von Dokumenten im elektronischen und

Papierformat sowie mündliche Dolmetscherdienste. Auf diese Weise soll Personen mit eingeschränkten Englischkenntnissen ein ungehinderter Informationszugang ermöglicht werden.

**हिंदी (Hindi):** अंग्रेज़ी का बहुत ज़्यादा ज्ञान न रखने वाले व्यक्तियों को सार्थक ऐक्सेस देने करने के लिए, St. Elizabeth Physicians ज़रूरी होने पर, निःशुल्क और सही समय पर भाषा सहायता सेवाएँ और उपयुक्त सहायक उपकरण प्रदान करता है, जिसमें इलेक्ट्रॉनिक और लिखित अनुवादित दस्तावेज़ और मौखिक व्याख्या शामिल हैं।

**日本語 (Japanese):** St. Elizabeth Physicians は、英語が苦手な人に意味あるアクセスを提供するために、電子のおよび書面による翻訳文書や口頭通訳を含む言語支援サービス及び適切な補助手段を、無料で適時に提供いたします。

**Kinyarwanda (Kirundi):** St. Elizabeth Physicians irungika serevise z'ugufasha ururimi n'imfashanyo z'abantu bafise ingorane mu kwumva, harimwo n'inyandiko z'ivy'ubuhinga bwa none n'uguhindura inyandiko yanditse n'ugusemura amajambo, ku buntu kandi mu buryo bubereye, mu kiringo izo serevise zikenewe kugira umuntu atazi neza icongereza ashobore kuronka izo serivisi azitahura neza.

**한국어 (Korean):** St. Elizabeth Physicians 는 영어 능력이 제한된 개인에게 의미 있는 접근성을 제공하기 위해 이러한 서비스가 필요할 때 무료로 적시에 전자 및 서면 번역 문서와 구두 통역을 포함한 언어 지원 서비스와 적절한 보조 도구를 제공합니다.

**नेपाली (Nepali):** St. Elizabeth Physicians ले सीमित अङ्ग्रेजी प्रविणता भएका व्यक्तिलाई अर्थपूर्ण पहुँच उपलब्ध गराउन आवश्यक हुँदा निःशुल्क रूपमा र समयमै विद्युतीय र लिखित अनुवादित कागजात र मौखिक अनुवादहरूलगायतका भाषासम्बन्धी सहायता सेवा तथा उपयुक्त सहायक सामग्रीहरू उपलब्ध गराउँछ।

**ਪੰਜਾਬੀ (Punjabi):** St. Elizabeth Physicians ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਉਪਕਰਣ ਪ੍ਰਦਾਨ ਕਰਦੀ ਹੈ, ਜਿਸ ਵਿੱਚ ਇਲੈਕਟ੍ਰਾਨਿਕ ਅਤੇ ਲਿਖਤੀ ਅਨੁਵਾਦ ਕੀਤੇ ਦਸਤਾਵੇਜ਼ ਅਤੇ ਮੌਖਿਕ ਵਿਆਖਿਆ ਸ਼ਾਮਲ ਹਨ, ਮੁਫਤ ਅਤੇ ਸਮੇਂ ਸਿਰ, ਜਦੋਂ ਅਜਿਹੀਆਂ ਸੇਵਾਵਾਂ ਦੀ ਲੋੜ ਸੀਮਤ ਅੰਗਰੇਜ਼ੀ ਮੁਹਾਰਤ ਵਾਲੇ ਵਿਅਕਤੀ ਨੂੰ ਅਰਥਪੂਰਨ ਪਹੁੰਚ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਹੁੰਦੀ ਹੈ।

**Русский (Russian):** В больнице St. Elizabeth Physicians бесплатно и своевременно предоставляются языковые услуги и другая помощь (в том числе услуги электронного, письменного и устного перевода), когда это необходимо, чтобы обеспечить полноценный доступ для лиц с ограниченным знанием английского языка.

**Srpsko-hrvatski (Serbo-Croatian):** St. Elizabeth Physicians pruža usluge jezičke pomoći i odgovarajuća pomoćna pomagala, uključujući elektronske i pismene prevedene dokumente i usmeni prevod, besplatno i blagovremeno, kada su takve usluge potrebne da bi se obezbedio smislen pristup osobi sa ograničenim znanjem engleskog jezika.

**Español (Spanish):** St. Elizabeth Physicians proporciona servicios de asistencia lingüística y ayudas auxiliares adecuadas, incluidos documentos electrónicos y escritos traducidos e interpretación oral, gratuita y oportunamente, cuando dichos servicios son necesarios para proporcionar un acceso significativo a una persona con dominio limitado del inglés.

**Tagalog (Tagalog):** Nagbibigay ang St. Elizabeth Physicians ng mga serbisyo ng tulong sa wika at naaangkop na mga auxiliary na tulong, kabilang ang mga electronic at nakasulat na mga isinaling dokumento at pasalitang interpretasyon, nang walang bayad at sa napapanahong paraan, kapag ang mga naturang serbisyo ay kinakailangan para magbigay ng makabuluhang pag-access sa isang indibidwal na limitado ang kahusayan sa Ingles.

**Tiếng Việt (Vietnamese):** St. Elizabeth Physicians cung cấp dịch vụ hỗ trợ ngôn ngữ và các phương tiện hỗ trợ phù hợp, bao gồm tài liệu dịch điện tử và văn bản cùng dịch vụ thông dịch, tất cả đều miễn phí và kịp thời khi các dịch vụ đó cần thiết cho cá nhân có trình độ Tiếng Anh hạn chế.