

WEIGHT LOSS QUESTIONNAIRE

Please give us some brief information about yourself and your weight loss goals.

Occupation/Work Schedule: _____

Diet History (types you've been on/results/lasting power): _____

Weight history (highest/lowest weights, when they occurred): _____

Current eating behaviors (foods, moods, situations that cause you to overeat, skipping meals, etc.) How often do you overeat? : _____

How did you hear about us? _____

How much weight do you expect to lose? _____

Each Week? _____ Each Month? _____

What size clothes do you expect to be able to wear when you reach your goal? _____

What in your life most effects the food that you eat? (examples: mood, schedule, convenience, cooking for others, cost) _____

How often do you consider the nutritional content of your food? (please circle)

Always

Usually

Sometimes

Rarely

Never

How many times a week do you eat out? _____

What are the most common places that you eat out? _____

What foods do you eat often that you know to provide poor nutritional content?

When do you most often eat these foods? _____

Do you currently exercise, and how often? _____

What types of activities do you do?

What do you expect/desire to do that you are not doing now? (be detailed): _____

What do you expect to STOP doing that you are doing now?

Do you believe that your habits can be changed with practice, education, and support? _____

Please circle all services that most interest you in a medical weight loss program:

- Medical monitoring including lab/blood tests and results
- Prescription appetite suppressant medication
- Vitamin and all-natural weight loss supplements
- Rapid Weight Loss
- Low-Calorie diet plan
- HCG diet
- Medical Meal-Replacements
- Nutrition education
- Accountability
- Support
- Counseling
- Lifestyle, habit, and behavior change
- Exercise guidance
- Hormone testing and/or treatment

Other: _____

What do you expect from us (Your medical counselors)? _____

Medical History

(Please circle all that apply)

- | | | |
|----------------------|-----------------------|--------------------|
| Dizzy Spells | Asthma/Short Breath | Cancer |
| High Blood Pressure | Chest Pain | Drug Addiction |
| High Cholesterol | Heart Attack | Smoking |
| Thyroid Problems | Stroke | Diabetes |
| Irregular Pulse | Heart Palpitations | Hypoglycemia |
| Heartburn or Ulcers | Alcohol Addiction | Migraines |
| Acid Reflux | Caffeine Sensitivity | Constipation |
| Hiatus Hernia | Gall Bladder Problems | Anemia |
| Spastic Colon | Kidney Problems | Hormone Imbalance |
| Convulsions/Seizures | Glaucoma | Menopause symptoms |
| Arthritis or Gout | Polycystic Ovaries | Joint Pain |
| Depression/Moodiness | Sleep Difficulties | Other: _____ |

Is there any other information we should have regarding your health history or weight loss goals?

Consent for Medical Weight Loss Services

Read and review each statement below carefully. If you have any questions about the risks of any proposed treatments, ask the medical provider before signing this form.

- I understand that I may be prescribed appetite suppressant medication as part of my weight loss program that may or may not include stimulants.
- I understand that the medical provider may require tests such as an EKG and blood pressure check before prescribing and/or continuing appetite suppressant prescriptions.
- I understand that the use of appetite suppressant medication involves some risks including dry mouth, headache, nervousness, rapid heart beat, high blood pressure, heart irregularities, irritability or other psychological problems, sleep difficulty, etc.
- I understand that it is my responsibility to carefully follow all instructions regarding any medications prescribed and report any significant medical problems as soon as reasonably possible.
- I understand that continuing to receive appetite suppressant medication will be dependant on compliance to nutrition plan/ weight reduction and approval by a medical provider based on medical evaluation.
- I understand that all appetite suppressant medications must be filled through Victory Pharmacy and will not be written or called in to an alternative pharmacy.
- I understand that some of the services offered such as the use of HCG and Lipo-B injections for weight loss are not FDA approved for weight reduction and/or treatment of obesity.
- I understand that these treatments have not been scientifically tested therefore absolute risks and benefits to these therapies are largely unknown.
- I understand that I have elected such treatments at my own risk after carefully considering potential risks and benefits.
- I understand that failure to comply with administration of medications exactly as instructed may increase risk to me.
- I understand that participation in the weight loss program requires a non-refundable membership fee that will not be billed to my insurance and must be paid out of pocket at the initial office visit.
- I understand that success of the program depends primarily on my own efforts and that there are no guarantees or assurances that the program will be successful.
- I understand that my program may also include counseling services provided by Meg Stephens, MA, NCC, LPC-intern, and such services will comply with ethical standards outlined by the Texas State Board of Examiners of Professional Counselors.
- I understand that other programs and methods can assist me in my weight reduction and maintenance efforts, and services may be discontinued at anytime.
- I understand that all services are non-refundable even if discontinued before completion of my program, and prices are subject to change without notice.
- I authorize William Franklin, MD, Sharon Shepherd, NP, Shawn Elander, NP, Anne Mickleburgh, PA, and Kelly Shook, PA to assist me in my weight loss efforts, and in signing this document hereby release them of any liability associated with services provided.

I _____ (patient name) have read and fully understand the above statements, and I accept primary assumption of risk associated with weight loss services provided by Victory Medical and Family Care.

Signature: _____ **Date:** _____