MEDICAL WEIGHT LOSS
at TRINITY MEDICAL ASSOCIATES

Enrollment Packet

Welcome Letter

CONGRATULATIONS!

Welcome to our program! You have taken the first step in losing your weight and changing your life.

We appreciate your entrusting your weight management education to us and allowing us to guide you on your weight management journey.

We promise to be there every step of the way to support you by celebrating your successes and helping you through your challenges.

We also encourage you to consider the support of friends and family. If you have friends or family who join our program, you both benefit from the additional support. Plus, you both will receive a special thank you from us.

We look forward to seeing you reach your goals and remind you to call us with any questions you may have. Congratulations on taking action and making this important decision!

Thank you,

Medical Weight Loss at Trinity Medical Associates LLC

Enrollment Application for the VLCD and LCD programs

CONFIDENTIAL

DATE: _____

NOTE: This form must be completed before you can be enrolled in the Numetra weight management program. Please answer every question. Please print, type or write clearly.

Name (Last-First-Initial)

Address (Street-City-State-Zip) | Daytime Phone No.

Occupation | Name of Employer | Evening Phone No.

Birth date (Month-Day-Year) | Circle Marital Status: Single Married Divorced Separated Widowed | SEX (CIRCLE): MALE FEMALE

Circle Level of Highest Education Completed

Grade School High School Some College College Grad Grad School Some Tech School Tech School Grad

Please give the name and address of a friend or relative with a stable address (for emergency)

Name (Last-First-Initial) | Address (Street-City-State-Zip) | Phone No.

Have you been treated at this health care facility before? □ Yes □ No

WEIGHT HISTORY

Patient weight (lbs)

Present height (feet, inches)

What is your goal weight?

When did you last weight this amount?

Indicate ages during which you were overweight

□ Childhood (Age 2-11 yrs)

□ Adolescence (Age 12-19 yrs)

□ Age 20-29 yrs

□ Age 30-40 yrs

□ Over 40 yrs

How much weight do you expect to lose during this program? _____ lbs.

Which weight loss methods have you tried in the past? Please be as specific as possible (eg. NutriSystem, Jenny Craig, Starvation, Protein Formula, Medications, Spa, Hypnosis, Weight Watchers, Psychotherapy, Etc.)

Weight loss method	How long was loss maintained?	Why did you stop treatment?	Problems during treatment
Sample: Stillman Diet	*2 months*	*Desired other foods*	*Dizziness*

Which weight loss method do you consider your most successful?

What accounted for that success?

MEDICAL HISTORY

Physician to receive your progress reports:

Name Office Address Phone

When was your most recent complete physical exam? Month: Year:

Please indicate whether you have ever used or are still using any of the following medications.

Ever Used	Still Using	Category	Name	Year Started	Dosage
		Lithium Carbonate			
		Corticosteroids			
		Phenothiazines			
		Diuretics (Water Pills)			
		Beta-Blockers			
		Ace Inhibitors			
		Calcium Channel Blockers			
		Insulin (types)			
		Oral Diabetic Agents			
		Thyroid Hormones			
		Birth Control Pills			
		Other Hormones			
		Tranquilizers			
		Antidepressants			
		Vitamin/Mineral Supplement			
		Aspirin or Acetaminophen			
		Fiber Supplement			
		Other			
		Other			

Please check any health condition you have:	□ Peptic ulcer disease that is not resolved or under good medical control
□ Heart attack within last 3 months	□ Recent onset of inflammatory bowel disease
□ Insulin-dependent diabetes (juvenile-onset diabetes)	□ Non-insulin dependent diabetes
□ Liver disease requiring protein restriction	□ Other (Explain)
□ Pregnant or planning to become pregnant within 6 months	
□ Kidney disease requiring protein restriction	Date of most recent menstrual period _____
□ Recent treatment for cancer (please describe)	Number of pregnancies _____
□ Recent uric acid kidney stone or untreated hyperuricemia	Weight gain with pregnancies _____ lbs

PSYCHOSOCIAL HISTORY

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

What other commitments do you that might interfere with your fully participating in Numetra Program?

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

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

PSYCHOSOCIAL HISTORY (CONT.)

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

1.

2.

3.

4.

5.

Why did you choose this particular program?

Are you currently in any kind of psychotherapy? □ YES □ NO
If yes, please specify:

With whom	For what	Date treatment began

Have you been in any kind of psychotherapy in the past? □ Yes □ No
If yes, please specify:

With whom	For what	Date treatment began	Ending date

Have you ever been hospitalized for psychiatric reasons? If so, please complete the following:

Date of Admission	Length of Stay	Reason for Hospitalization

Have you ever had suicidal thoughts?	Have you ever been severely depressed?	Have you ever experienced dramatic mood changes during dieting (especially anxiety or depression)?
□ Yes □ No	□ Yes □ No □ Possibly	□ Yes □ No □ Possibly

Have you ever eaten a large amount of food rapidly and felt this eating incident was excessive and out of control (aside from holiday feasts)? □ Yes □ No

If yes, how often did you do this during the past year? (check one)

□ Less than once a month
□ About once a month
□ A few times a month
□ About once a week
□ About three times a week
□ Daily

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

LIFESTYLE AND EATING HABITS

Do you drink alcohol? □ Yes □ No

If yes, how much?
□ 1 drink a month
□ 1 drink a week
□ More than 1 drink a week
□ 1 drink a day
□ More than 1 drink a day

How often do you exercise?
□ Rarely
□ Occasionally
□ 1-2 times a week
□ 3-4 times a 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 you answered 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, McDonald's)? □ Yes □ No

Usually in cafeteria/restaurant? □ Yes □ No

LIFESTYLE AND EATING HABITS (CONT.)

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) _____

_____

_____

Are you allergic to

Cocoa?	□ Yes	□ No
Milk protein?	□ Yes	□ No
Corn?	□ Yes	□ No
Soy?	□ Yes	□ No
Eggs?	□ Yes	□ No

Other food? (describe) _____

Are you sensitive to or do you have a problem with

Aspartame (Nutrasweet)?	□ Yes	□ No
Monosodium glutamate (MSG)?	□ Yes	□ No
Lactose? (unable to drink milk but able to eat cheese and yogurt)	□ Yes	□ No

Do you smoke? □ Yes □ No

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

_____ _____

Signature Date

I give permission for the data provided in this from and obtained in subsequent visits and interviews to be submitted to Trinity Medical Associates LLC for the purpose of group evaluation of data. Except for the purpose of matching current and future data, my name will not be used in conjunction with any of the data. I understand that such group evaluation may, from time to time, be used in publications or other materials, but that participant confidentiality will be maintained.

_____ _____

Signature Date

FOR TMA USE ONLY

Medical Information for Enrollment

Patient's Name:_____

I. MEDICATIONS

Please list all medications, including prescription drugs and OTC medications.

Drug	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

II. MEDICAL PROBLEMS ASSOCIATED WITH OBESITY

Please check the appropriate diagnoses in the box and provide information indicated.

☐ HYPERTENSION

Onset (age)	Most recent BP	Check one: ☐ Well controlled ☐ Sporadically controlled ☐ Poorly controlled

☐ ARTERIOSCLEROTIC HEART DISEASE

Manifested by angina ☐ Yes ☐ No	Onset (age)	Infarction dates	Functional heart classification:	
Manifested by myocardial infarction ☐ Yes ☐ No				
Has the patient had treadmill or step exercise in the past 4 months? ☐ Yes ☐ No Date:		If the patient is seeing a cardiologist, please give his/her name:		

☐ HYPERURICEMIA OR GOUT

Onset (age)	History of :	
	Renal Lithiasis? ☐ Yes ☐ No	Were stones documented as containing uric acid? ☐ Yes ☐ No
	Gouty Arthritis? ☐ Yes ☐ No	Tophi? ☐ Yes ☐ No

☐ DEGENERATIVE ARTHRITIS

Weight bearing joints:	Location of predominant involvement:

☐ DIABETES MELLITUS

Onset (age)			Does the patient have:	
	History of diabetic ketoacidosis?	☐ Yes ☐ No	Diabetic retinopathy	☐ Yes ☐ No
	Insulin dependent?	☐ Yes ☐ No	Neuropathy	☐ Yes ☐ No
	Receiving oral hypoglycemics?	☐ Yes ☐ No	Proteinuria	☐ Yes ☐ No

☐ HYPERLIPIDEMIA

Onset (age)	Predominately:		Is phenotype known? (Please describe)
	Cholesterol elevated	☐ Yes ☐ No	
	Triglycerides elevated	☐ Yes ☐ No	
	Both elevated	☐ Yes ☐ No	

History of skin involvement?

Other problems you attribute to obesity	Additional comments:

III. ALLERGIES OR UNUSUAL REACTIONS

Indicate with an asterisk (*) foods or medications that definitely are contraindicated.

Medication or Food	Reaction
1.	
2.	
3.	
4.	

IV. DISABILITY

Please rate each obesity-related disability	0 None	1 Mild (inconvenienced)	2 Moderate (limited activity)	3 Severe (total)
Type of objective obesity-related disability	0	1	2	3
Respiratory (Dyspnea, Hypoventilation, Hypoxia)	0	1	2	3
Cardiac (Angina, Congestive heart failure, Dependent edema, Hypertension)	0	1	2	3
Orthopedic (Arthralgas, Tendon injury, Low-back pain)	0	1	2	3
Metabolic (Diabetes, Hyperlipidemia, Gout)	0	1	2	3
Functional (Cannot tie shoes or fit in chairs, etc.)	0	1	2	3
Overall	0	1	2	3

Comments, if any:

V. WEIGHT

Patient's present weight (lbs.): The weight (lbs.) you would like to see this patient achieve:

Following is a list of conditions that possibly would preclude participation in the New Direction® System, which has high protein content and promotes ketosis. If your patient has any of these conditions, you should discuss this patient with the consulting New Direction physician before referral.

A. Recent myocardial infarction (within 3 months)

B. Total insulin dependency, juvenile-onset diabetes mellitus

C. Liver disease requiring protein restriction

D. Pregnancy or planned pregnancy

E. Renal disease requiring protein restriction

F. Recent treatment of malignant tumor, particularly if metastatic disease is still possibly present

G. Clearly psychotic, being treated with phenothiazines

H. Age less than 18 years; full growth potential not attained

I. Recent uric acid renal stone or untreated hyperuricemia

J. Peptic ulcer disease that is not resolved or under good medical control

K. Recent onset of inflammatory bowel disease

L. Treatment with lithium carbonate

M. Treatment with corticosteroids

Please print your name (last, first, middle initial)	Address Specialty	Office phone number: Hospital phone number:
Your signature	Date	
Initials A ☐ B ☐ C ☐	For TMAoffice use only	

Diet Readiness Behavioral Questionnaire

For each question, circle the answer that best describes how you feel.

Section 1: Goals and Attitudes

1. Compared to previous attempts, how motivated to lose weight are you this time?

1	2	3	4	5
Not At All Motivated	Slightly Motivated	Somewhat Motivated	Quite Motivated	Extremely Motivated

2. How certain are you that you will stay committed to a weight loss program for the time it will take to reach your goal?

1	2	3	4	5
Not At All Certain	Slightly Certain	Somewhat Certain	Quite Certain	Extremely Certain

3. Consider all outside factors at this time in your life (the stress you're feeling at work, your family obligations, etc). To what extent can you tolerate the effort required to stick to a diet?

1	2	3	4	5
Cannot Tolerate	Can Tolerate Somewhat	Uncertain	Can Tolerate Well	Can Tolerate Easily

4. Think honestly about how much weight you hope to lose and how quickly you hope to lose it. Figuring a weight loss of 1 to 2 pounds per week, how realistic is your expectation?

1	2	3	4	5
Very Unrealistic	Somewhat Unrealistic	Moderately Unrealistic	Somewhat Realistic	Very Realistic

5. While dieting, do you fantasize about eating a lot of your favorite foods?

1	2	3	4	5
Always	Frequently	Occasionally	Rarely	Never

6. While dieting, do you feel deprived, angry and/or upset?

1	2	3	4	5
Always	Frequently	Occasionally	Rarely	Never

Section 1 TOTAL SCORE _____

Section 2: Hunger and Eating Cues

7. When food comes up in conversation or in something you read, do you want to eat even if you are not hungry?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

8. How often do you eat because of physical hunger?

1	2	3	4	5
Always	Frequently	Occasionally	Rarely	Never

9. Do you have trouble controlling your eating when your favorite foods are around the house?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

Section 2 TOTAL SCORE _____

Section 3: Control Over Eating

If the following situations occurred while you were on a diet, would you be likely to eat more or less immediately afterward and for the rest of the day?

10. Although you planned on skipping lunch, a friend talks you into going out for a midday meal.

1	2	3	4	5
Would Eat Much Less	Would Eat Somewhat Less	Would Make No Difference	Would Eat Somewhat More	Would Eat Much More

11. You "break" your diet by eating a fattening, "forbidden" food.

1	2	3	4	5
Would Eat Much Less	Would Eat Somewhat Less	Would Make No Difference	Would Eat Somewhat More	Would Eat Much More

12. You have been following your diet faithfully and decide to test yourself by eating something you consider a treat.

1	2	3	4	5
Would Eat Much Less	Would Eat Somewhat Less	Would Make No Difference	Would Eat Somewhat More	Would Eat Much More

Section 3 TOTAL SCORE _____

Section 4: Binge Eating and Purging

13. Aside from holiday feasts, have you ever eaten a large amount of food rapidly and felt afterward that this eating incident was excessive and out of control?

2	0
Yes	No

14. If you answered yes to #13, how often have you engaged in this behavior during the last year?

1	2	3	4	5	6
Less Than Once A Month	About Once A Month	A Few Times A Month	About Once A Week	About Three Times A Week	Daily

15. Have you ever purged (used laxatives, diuretics or induced vomiting) to control your weight?

5	0
Yes	No

16. If you answered yes to #15 above, how often have you engaged in this behavior during the last year?

1	2	3	4	5	6
Less Than Once A Month	About Once A Month	A Few Times A Month	About Once A Week	About Three Times A Week	Daily

Section 4 TOTAL SCORE _____