In Balance
Women's Focused Weight Loss

Dear Patient,

Thank you for your interest in our medically supervised weight loss program.

Please fill out the following intake form and return it to the office before you schedule your first visit

- Fax (914) 948-1019 attn: Dawn
- Email dcastelli@westmedgroup.com

This intake form has **two** purposes

1. Identify codes we can submit to your insurance company
    a. Insurance companies do not generally cover weight loss per se
    b. However, they will cover the "co-morbidities" (or complications) associated with excess weight
    c. If your BMI is greater than 30, they should cover unless you have an "obesity exclusion"
    d. They may also cover if your BMI is greater than 27 with one or more co-morbidities
2. Identify issues you have been struggling with in your efforts to lose and maintain a healthy weight and lifestyle
    a. This information will provide the supporting documentation that your insurance company requires to cover these services so please do your best to answer ALL the questions

Since your information will be reviewed before your visit, our first session can focus on education and other weight loss tools to get you started right away on the path to a healthier you.

After we receive your completed forms, we will provide you with the "ICD codes" corresponding to these co-morbidities. Please call your insurance and check if they are covered. Pre-authorization is not required. Please be aware that all visit codes will be billed as "problem visits" (as weight loss is not considered preventative) and may be subject to a co-pay or deductible. If your insurance does not cover the program, you may ask about our self-pay rates.

To **schedule** or **reschedule** any of these appointments, please contact Dawn directly. Otherwise your appointment may not be scheduled correctly and may need to be rescheduled.

Please be courteous of our scheduling procedures. If you are unable to keep your appointment please contact the office to cancel. We understand that "things come up" but please take the time to reach out to us. This will allow sufficient time for another patient to schedule their appointment. Rather than charging a no-show fee, after **two** no-show appointments, we will no longer be able to take to care of you.

Thanks for your time
Julianne Dunne, MD

Name_____**DOB**_____**Date**_____

Medical, Social and Nutrition History

Height	
Current weight	
Goal weight	
Age when last at goal weight	

Which statement describes you the best?

☐ I believe I am eating healthy foods in healthy quantities and I am getting regular exercise. So I don't understand why I am not a healthy size!

☐ I know which healthy foods to eat and what types of healthy activities I should be doing, but I have a difficult time starting and/or sticking to a plan.

☐ I am truly confused regarding which foods are healthy and what exercise or activities are the best because there is too much confusing or conflicting information in the media.

☐ Help me! I don't know even where to start!

YOUR MEDICAL HISTORY

Have you been diagnosed with or treated for any of the following conditions?

☐ heart disease ☐ previous heart attack ☐ stroke
☐ high cholesterol ☐ elevated triglycerides
☐ high blood pressure ☐ gestational hypertension (high blood pressure in pregnancy) ☐ pre-eclampsia
☐ fatty liver disease ☐ gastric reflux disease
☐ insulin resistance ☐ diabetes ☐ polycystic ovarian syndrome ☐ hypothyroidism ☐ hyperthryoidism
☐ asthma ☐ COPD ☐ restrictive airway disease ☐ sleep apnea
☐ osteoarthritis ☐ herniated disk(s) ☐ osteoporosis
☐ rheumatoid arthritis ☐ colitis ☐ other autoimmune conditions_____
☐ depression ☐ anxiety
☐ breast cancer ☐ colon cancer ☐ uterine cancer ☐ other cancer_____
☐ other(s), please list

When was your last?	Date	Provider	Result
Physical Exam?			
Pap smear?			
Mammogram?			
Colonoscopy?			

MEDICATION

List any medications, vitamins or herbal remedies you are currently taking on a regular basis.

Drug name	Dosage	How often?	Purpose

Have you ever taken any weight loss medications (prescription or over-the-counter)? ☐ none

Drug name	Dosage	How often?	Last taken?

ALLERGIES

List any medications you are allergic to and reaction. ☐ none Are you allergic to latex? ☐ yes ☐ no

_____ ☐ rash or hives ☐ swelling of lips or tongue ☐ anaphylaxis

_____ ☐ rash or hives ☐ swelling of lips or tongue ☐ anaphylaxis

_____ ☐ rash or hives ☐ swelling of lips or tongue ☐ anaphylaxis

SURGERIES/HOSPITALIZATIONS:

Please list any operations or illness that required hospitalization.

Year	Surgical procedure or reason for hospitalization	Year	Surgical procedure or reason for hospitalization

FAMILY HISTORY

Has any blood relative ever had any of the following conditions? Please indicate by <u>circling</u> which family member affected and/or <u>writing in</u> maternal aunt or paternal grandfather, etc.

Diabetes	Mother	Father	other_____
High blood pressure	Mother	Father	other_____
Heart disease	Mother	Father	other_____
Cholesterol or lipid problems	Mother	Father	other_____
Obesity	Mother	Father	other_____
Asthma	Mother	Father	other_____
Kidney disease	Mother	Father	other_____
Thyroid disease	Mother	Father	other_____
Liver disease	Mother	Father	other_____
Neurologic disorders	Mother	Father	other_____
Alzheimer's dementia	Mother	Father	other_____
Breast cancer	Mother	Father	other_____
Colon cancer	Mother	Father	other_____
Other_____	Mother	Father	other_____

GYNECOLOGIC HISTORY

When was the <u>1st day</u> of your last period?_____ At what age did you have your first period?_____

Are your periods regular? ☐ yes ☐ **no** My periods are ☐ light ☐ moderate ☐ heavy ☐ heavy with clots

If in menopause, what year was your last period? _____

Are you having ☐ hot flashes ☐ irritability ☐ vaginal dryness ☐ painful intercourse ☐ difficulty sleeping?

Are you currently sexually active? ☐ yes ☐ no Are you currently **planning pregnancy**? ☐ yes ☐ no

If you are not planning pregnancy, which of the following methods are you using? ☐ **none**

☐ condoms ☐ pills/Nuvaring ☐ depo-provera ☐ Nexplanon ☐ Mirena/Skyla ☐ Paragard ☐ vasectomy ☐ tubal ligation/Essure

OBSTETRIC HISTORY

How many times have you been pregnant?_____ How many live births?_____

If you have children, were they delivered by ☐ vaginal birth ☐ cesarean delivery ☐ both

SOCIAL HISTORY

Marital status: ☐ S ☐ M ☐ W ☐ D ☐ Sep Who lives at home with you?_____

What is your occupation? _____ Describe: ☐ desk job ☐ stand on feet often ☐ heavy lifting

Describe your commute to work: ☐ drive ☐ take public transportation ☐ walk to work ☐ bike to work

Do you smoke cigarettes? ☐ never ☐ former smoker ☐ current smoker

If a **former/current smoker**, how many packs? ☐ <1 pack per day ☐ 1 ppd ☐ 1-2 ppd ☐ >2 ppd

Do you drink alcohol? ☐ 0-12 drinks/year ☐ 1-13 drinks/month ☐ 4-14 drinks/week ☐ >2 drinks/day

Have you ever been treated for alcohol abuse? ☐ no ☐ yes

Do you use recreational drugs? ☐ no ☐ yes _____ Have you ever been treated for drug abuse? ☐ no ☐ yes

NUTRITION HISTORY

What was your **birth weight**? ☐ below average ☐ average weight ☐ above average
Were you delivered by ☐ vaginal birth or ☐ cesarean section? Were you primarily ☐ breast fed or ☐ bottle fed ☐ unsure
Was your **mother** overweight at the time of your **conception**? ☐ yes ☐ no During **your childhood**? ☐ yes ☐ no
Was your **father** overweight at the time of your **conception**? ☐ yes ☐ no During **your childhood**? ☐ yes ☐ no

What are your **main reasons** for your decision to lose weight?_____
_____
When did you **begin** gaining excess weight? (at what age or what year and give reasons, if known): _____
_____
Did you start to gain weight after a **life stress**? ☐ marriage ☐ childbirth ☐ divorce ☐ menopause ☐ other_____
_____
Did you gain weight after starting any medication? ☐ yes ☐ no Which one(s)?_____
What was your weight at **20 years** of age: _____ Your weight **1 year** ago: _____
What has been your **maximum lifetime** weight (non-pregnant) and when?_____
What has **improved** your weight? List past successes_____
_____
What are the **challenges** that you think hinder your success? _____
_____

FOOD TRIGGERS

What **triggers** you to eat or overeat? ☐ stress ☐ boredom ☐ comfort ☐ blame ☐ eating certain foods ☐ other
Please describe_____
_____
List any **specific foods** that trigger your hunger_____
When you eat certain foods can you **easily stop**? ☐ yes ☐ **no**
Are you compelled to eat until all the **food is gone**? ☐ **yes** ☐ no
If you have certain foods in your immediate environment, do you feel you **must eat** them? ☐ **yes** ☐ no
Are you easily full? ☐ yes ☐ **no**
Do you find you cannot get full? ☐ **yes** ☐ no
Do you feel less panicky or feel relief after eating? ☐ **yes** ☐ no
Do you have difficulty resisting temptations? ☐ **yes** ☐ no

FOOD HABITS

What foods do you **crave**? _____
Is there any specific **time of day** or **month** that you crave food? _____
Do you drink regular soda, sweetened tea or juices? ☐ **yes** ☐ no How many daily?_____
Do you drink Starbucks or other gourmet coffee drinks? ☐ **yes** ☐ no What is your favorite? _____
Do you use **sugar substitutes**? ☐ **yes** ☐ no
Do you awaken hungry during the night? ☐ **yes** ☐ no If yes, what do you do?_____
What are your **worst food habits**?_____
_____
Do you skip meals or have inconsistent meal patterns? ☐ **yes** ☐ no
What do you have for **snacks** between meals?_____
What access to food do you have at work? ☐ vending machines? ☐ cafeteria ☐ snack bar ☐ other_____
How often is food brought into your office for celebrations or just brought in?_____
Do you **bring your lunch** to work? ☐ yes ☐ **no** Do you have a **secret stash** draw at work? ☐ **yes** ☐ no
Do you **eat differently** when no one else is around? ☐ **yes** ☐ no
Do you eat while watching TV, working on the computer or going to the movies? ☐ **yes** ☐ no
Have you ever used laxatives to lose weight? ☐ **yes** ☐ no Have you ever thrown up after eating? ☐ **yes** ☐ no
Do you **reward** yourself with food? ☐ **yes** ☐ no If yes, for what reasons?_____

Is your **spouse/significant** other? ☐ below average weight ☐ average weight ☐ above average ☐ very heavy
Are any of your **children** overweight? ☐ yes ☐ no
How often do you eat out? _____
What **restaurants** do you frequent? _____
When you eat out which of the following do you have? ☐ alcoholic drink ☐ appetizer ☐ entree ☐ dessert
How often do you eat **fast foods**? _____
When you eat out do you **share** meals or parts of meals? ☐ yes ☐ **no**
Who plans meals?_____ Cooks?_____ Shops? _____ Do you use a **shopping list**? ☐ yes ☐ no
What time of day and on what day do you usually **shop for groceries**? _____

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DIET HISTORY
List **previous diets** you have followed:

	Dates	Weight (lost or gained)	Length of participation
Weight watchers			
Nutrisystem			
Jenny Craig			
Liquid diets (Optifast)			
Overeaters Anonymous			
Medifast			
OTC diet pills			
Weight Loss surgery			

Have you **maintained any weight loss** for up to 1 year on any of these programs? ☐ yes ☐ no
What did you **learn** from these programs regarding your weight?_____
What did **not work** about these programs?_____

PHYSICAL ACTIVITY ASSESSMENT
Are you currently exercising? ☐ **no** ☐ yes. If yes

	Type of activity	**How long?**	**How often?**
	Walking		
	Swimming		
	Bicycle		
	Exercise class		
	Weight lifting or resistance training		
	Yoga/Pilates		
	Gardening		

If no, what keeps you from exercising? ☐ no time ☐ too expensive ☐ too tired ☐ too boring ☐ physical impairment
☐ gym or group classes are intimidating ☐ don't like to sweat ☐ other_____
Please list any activities you enjoyed in the past or as a child_____
Do you have someone who will exercise with you? _____
What types of exercise do you dislike?_____
What type of exercise can you/are you willing to do right now?_____

SLEEP HISTORY
Briefly describe your sleep pattern_____
_____
Do you **snore** extremely loud so that you may be heard from another room? ☐ **yes** ☐ no
Do you often feel **tired**, fatigued or sleepy during the daytime ☐ **yes** ☐ no
Has anyone **observed** you stop breathing during your sleep? ☐ **yes** ☐ no
Have you ever had a sleep study? ☐ **yes** ☐ no If yes, what were the results?_____

THE EPWORTH SLEEPINESS SCALE
Use the scale below to choose the most appropriate number for each situation

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g. in a theater)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	

PSYCHOSOCIAL HISTORY

Have you ever participated in counseling or psychotherapy? ☐ yes ☐ no
Have you ever been treated for depression? ☐ yes ☐ no
Have you ever been treated for an anxiety disorder? ☐ yes ☐ no
Do you currently take any medications for depression or anxiety? ☐ yes ☐ no
If yes, which ones_____
Do you have a family history of mental illness? ☐ yes ☐ no
If you answered **yes to any questions above** and want to provide more information, please do so here:
_____
_____

Have you ever been treated for alcohol dependence? ☐ yes ☐ no
Have you ever been treated for drug addiction? ☐ yes ☐ no
Do you have a family history of addiction (alcohol or drug abuse?) ☐ yes ☐ no
Have you ever been a victim of abuse (physical, emotional or sexual?) ☐ yes ☐ no
If yes, have you ever received counseling? ☐ yes ☐ no
If you answered **yes to any questions above** and want to provide more information, please do so here:
_____
_____

Are you planning any major life changes in the next year? ☐ yes ☐ no
If so, what? _____
_____

What is the most significant source of stress at this time?_____
_____

When you are under a stressful situation at work or family-related do you tend to eat more? Explain
_____
_____

Do you think you are currently undergoing a stressful situation or an emotional upset? Explain
_____
_____

What is your method of coping with stress?_____
_____

Who will make up your support team?_____
_____

What is their relationship to you? _____
_____

Please describe any other comments or concerns_____
_____
_____
_____
_____

HORMONAL BALANCE QUESTIONNAIRE

Read carefully through the list of symptoms. Put a checkmark (✔) next to any you experience. Note each part should be answered separately. Some answers may be repeated. We can periodically repeat this survey to assess your progress!

Do you have or have you experienced in the past 6 months…

CORTISOL EXCESS

☐ Difficulty falling asleep or disrupted sleep? Or a second wind that keeps you up late?
☐ Feeling wired yet tired?
☐ Constantly racing from one task to the next?
☐ Sugar cravings (you need "a little something" after each meal, usually chocolate!)?
☐ Gaining weight around your abdomen, even when you eat well and exercise?
☐ A feeling of anxiety or nervousness—can't stop worrying about things beyond your control?
☐ A quickness to feel anger or rage—frequent screaming or yelling?
☐ Memory lapses or feeling distracted, especially under duress?

CORTISOL DEFICIENCY

☐ Fatigue or burnout? Loss of stamina, particularly from 2 to 5 in the afternoon?
☐ Crying spurts for no particular reason?
☐ Feeling stressed most of the time (everything seems harder than before, or trouble coping?)
☐ Insomnia or difficulty staying asleep, especially between one and four in the morning?
☐ Salt cravings?
☐ Excess sweating?
☐ Nausea, vomiting, or diarrhea? Or loose stool alternating with constipation?
☐ Muscle weakness, especially around the knees? Muscle or joint pain?

ESTROGEN DEFICIENCY

☐ Poor memory (you walk into a room to do something, then forget what it was)?!
☐ Emotional fragility, especially compared with how you felt ten years ago)?
☐ Depression, perhaps with anxiety or lethargy?
☐ Night sweats or hot flashes?
☐ Trouble sleeping, waking up in the middle of the night?
☐ A leaky or overactive bladder?
☐ Vaginal dryness, irritation, or loss of feeling?
☐ Low libido? Painful sex?

ESTROGEN EXCESS

☐ Bloating, puffiness, or water retention?
☐ Heavy bleeding?
☐ Rapid weight gain, particularly in the hips and butt?
☐ Endometriosis or painful periods?
☐ Mood swings, PMS, depression, or just irritability? Weepiness, sometimes over the most ridiculous things?
☐ Mini breakdowns or anxiety?
☐ Migraines or other headaches?
☐ Insomnia?
☐ Brain fog?

PROGESTERONE DEFICIENCY

☐ Agitation or PMS?
☐ Cyclic headaches (particularly menstrual or hormonal headaches)?
☐ Irregular menstrual cycles, or cycles becoming more frequent as you age?
☐ Heavy or painful periods (heavy: soaking a pad every 2 hours or pain: can't function without ibuprofen)?
☐ Bloating, particularly in the ankles and belly, and/or fluid retention?
☐ Easily disrupted sleep?
☐ Itchy or restless legs, especially at night?
☐ Increased clumsiness or poor coordination?

ANDROGEN EXCESS

☐ Excess hair on your face, chest, or arms?
☐ Acne? Greasy skin and/or hair?
☐ Thinning hair on your head?
☐ Discoloration of your armpits (darker and thicker than your normal skin)?
☐ Skin tags, especially on your neck and upper torso?
☐ Reactivity and/or irritability, or excessively aggressive or authoritarian episodes?
☐ Depression? Anxiety?
☐ Menstrual cycles occurring more than every 35 days?
☐ Infertility? Or subfertility (no pregnancy < 12 months of trying)?

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REVIEW OF SYMPTOMS

Do you have any of the following **general symptoms**?
☐ fatigue ☐ difficulty sleeping ☐ snoring ☐ daytime sleepiness ☐ forgetfulness

Do you have any of the following **visual symptoms**?
☐ blurry vision ☐ double vision ☐ loss of vision

Do you have any of the following **ear, nose or throat symptoms**?
☐ sore throat ☐ hoarseness ☐ nasal/sinus problems

Do you have any of the following **cardiovascular symptoms**?
☐ chest pain ☐ palpitations ☐ leg swelling ☐ passing out ☐ sudden awakening from sleep with shortness of breath ☐ varicose veins ☐ hemorrhoids

Do you have any of the following **pulmonary symptoms**?
☐ shortness of breath ☐ wheezing ☐ blood in sputum ☐ sleep apnea

Do you have any of the following **gastrointestinal symptoms**?
☐ gastric reflux/heartburn ☐ gallstones ☐ constipation ☐ vomiting/diarrhea ☐ abdominal pain ☐ blood in stool

Do you have any of the following **urinary symptoms**?
☐ loss of urine ☐ frequent urination ☐ prolapsed bladder or uterus ☐ blood in urine

Do you have any of the following **musculoskeletal symptoms**?
☐ low back pain ☐ knee pain ☐ joint pain/swelling ☐ muscle pain/cramps ☐ muscle stiffness

Do you have any of the following **skin conditions**?
☐ acne ☐ eczema ☐ dark skin around neck or groin ☐ stretch marks ☐ skin tags ☐ skin ulcers

Do you have any of the following **neurologic symptoms**?
☐ frequent headache ☐ weakness ☐ carpal tunnel syndrome ☐ impaired balance ☐ numbness or tingling

Do you have any of the following **psychological symptoms**?
☐ depression ☐ stress/anxiety ☐ poor self-image ☐ social isolation

Do you have any of the following **endocrine symptoms**?
☐ heat or cold intolerance ☐ increased thirst ☐ excessive sweating

Do you have any of the following **allergic symptoms**?
☐ hives ☐ hay fever ☐ food allergies or sensitivities ☐ frequent infections

Do you have any of the following **gynecologic symptoms**?
☐ irregular periods ☐ painful periods ☐ heavy periods ☐ genital itch or discharge ☐ premenstrual syndrome ☐ low sex drive ☐ painful intercourse

Do you have any of the following **reproductive symptoms**?
☐ infertility ☐ miscarriage ☐ pregnancy complications _____

ARE YOU READY TO MAKE SOME CHANGES?
Choose the reason(s) that best describes why you are pursuing a weight loss program at this time?

☐ To avoid medical disability in the future
☐ To better manage current medical problems
☐ To avoid or reduce social criticism from others
☐ To feel better about myself
☐ Other_____

Importance of Change
On a scale of 1-10, where 1 is not important and 10 is most important, how important is it for you to change your diet and lifestyle habits to lose weight? 1 2 3 4 5 6 7 8 9 10 (circle one)

Readiness to Change
On a scale of 1-10, where 1 is not ready to change and 10 is absolutely ready to change, how ready are you to change your diet and lifestyle habits to lose weight? 1 2 3 4 5 6 7 8 9 10 (circle one)

Confidence in Ability to Change
On a scale of 1-10, where 1 is not confident at all and 10 is absolutely confident, how confident are you in your ability to change your diet and lifestyle habits to lose weight? 1 2 3 4 5 6 7 8 9 10 (circle one)

What do **you think** would make the most difference in your overall health?_____
_____
_____
_____

In order to improve your health, **how willing are you to**
Rate on a scale of **1** (not willing at all) to **5** (very willing)

Significantly modify your diet and try new foods	1 2 3 4 5 (circle one)
Keep a record of everything you eat each day	1 2 3 4 5 (circle one)
Modify your lifestyle (e.g. work demands, sleep habits, exercise)	1 2 3 4 5 (circle one)
Engage in regular physical activity	1 2 3 4 5 (circle one)
Practice a daily relaxation technique	1 2 3 4 5 (circle one)
Take nutritional supplements when recommended	1 2 3 4 5 (circle one)
Have periodic lab tests to assess your progress	1 2 3 4 5 (circle one)

3 DAY FOOD DIARY

Tell me about your **typical day's eating habits** (and include beverages, sweeteners) for at least one or more days

	Day 1	Day 2	Day 3
Breakfast Time_____			
Snack Time_____			
Lunch Time_____			
Snack Time_____			
Dinner Time_____			
Snack Time_____			

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