Center for Psychiatry and Weight Management

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Dear Patient,

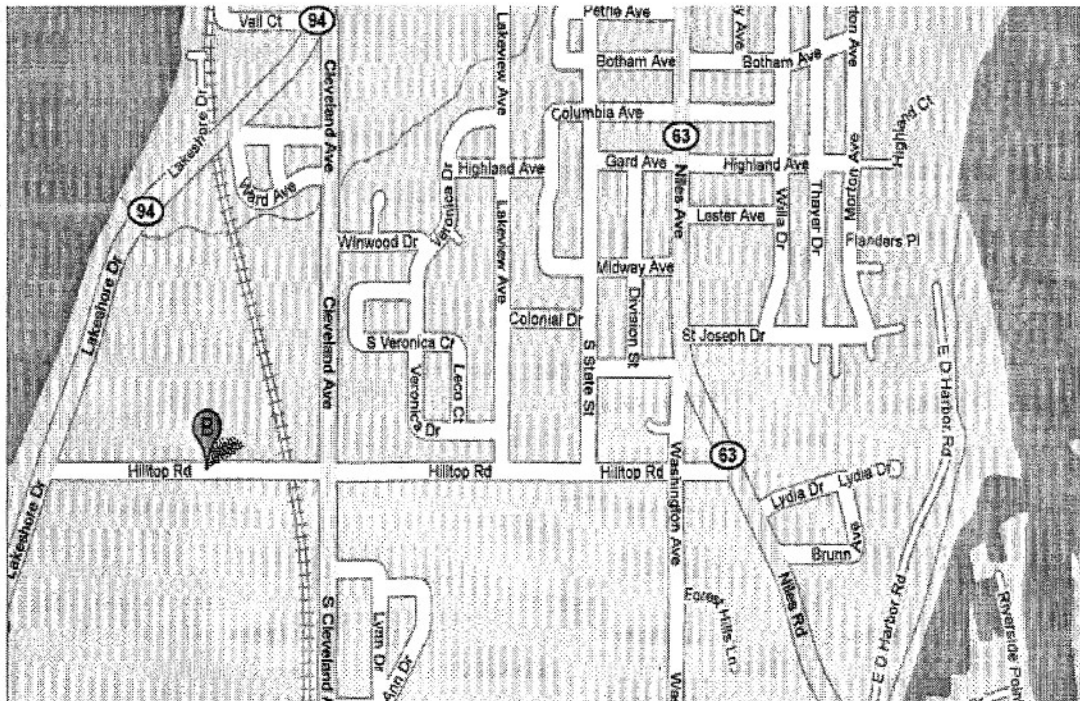
Welcome to our practice. To better serve you, we have developed the enclosed patient history packet.

Please complete all the forms and bring them with you for your first appointment scheduled for

____@_____________.

As a reminder, payment is expected in full at the time of service. Co-payments are accepted with, and only with insurances we participate with. There are no exceptions unless arrangements in writing have been made with our office ahead of time. Please contact our office if you have questions.

As we discussed on the telephone, we do / don't participate with your insurance.



NEW PATIENT EVALUATION CHECKLIST

Please use this checklist as a reminder of what you will need to bring with you at the time of your initial appointment. Remember to arrive 15 minutes early, to allow sufficient time to complete all required paperwork.

1. Completed Medical History Form.

2. Copy of any laboratory tests completed within the last six months. You can either obtain copies of these labs results and bring them to your first appointment, or contact your health care provider by phone and request they fax them to our office @ (269) 983-5763. Failure to provide appropriate labs at your initial appointment may cause delay in initiation of possible medication treatment until laboratory testing is completed.

3. Patients with a positive history of heart disease, high cholesterol, diabetes (type I or II), high blood pressure, and/or a positive family history of heart disease, will be required to have and EKG performed or provide a copy of one completed within the past 12 months, prior to implementation of pharmacological treatment.

4. Patients with a prior history of using the weight loss medication Phen-Phen / Redux (fenfluramine), will be required to have a complete cardiac workup (including an EKG and echocardiography), or provide appropriate record of such workup, prior to implementation of pharmacological treatment Feel free to contact our office if you need a referral to a cardiologist, or want information on how your cost of your cardiac workup may be covered under past legal settlement.

5. Bring a valid driver's license, valid/current major credit card, and all appropriate insurance information

6. The length of this initial appointment may range from 40 to 60 minutes, so plan your schedule accordingly.

Thank you for choosing our office to assist you with your needs. We very much look forward to meeting with you and helping you achieve your health goals. For anyone who is interested, you can learn more about us by accessing our website at www.manageyourweight.com .

Sincerely,
Dr. Dennis Padla

DATE OF EVALUATION________________ REFERRAL SOURCE____________

PRIMARY CARE PHYSICIAN ______________________________

PRIMARY INSURANCE____________________________________

SECONDARY INSURANCE_________________________________

IDENTIFYING INFORMATION

NAME__________________________ AGE___ RACE_____ SEX M/F

MARITAL STATUS M/W/D/S SIGNIFICANT OTHERS NAME_________

OCCUPATION____________________

ADDRESS_______________________________________
CITY_________________________ ST__________ ZIP____________

HOME PHONE ________________ WORK PHONE_______________

HISTORY OR PRESENTING PROBLEM

(Include chief complaint: all symptoms you feel, how long you've felt this way, any suicidal thoughts).

____
____
____
____
____
____
____
____

PAST PSYCHIATRIC HISTORY

(Include all psychiatric medications used in the past).

____
____
____
____
____
____
____
____

PATIENT MEDICAL HISTORY

PAST MEDICAL HISTORY

____

____

____

DATE OF YOUR LAST COMPLETE PHYSICAL EXAM______________________

If you have had any of the following health problems, please check the appropriate box, then provide the date the problem occurred and a brief description of the problem. Use the back or the page if necessary.

1. DIABETES______________________________
2. RESPIRATORY DISORDERS______________________
3. SEIZURES (EPILEPSY)________________________
4. NEUROLOGICAL (STROKE) ____________________
5. CANCER AND TYPE _________________________
6. HIGH BLOOD PRESSURE______________________
7. HEART DISEASE___________________________
8. ORTHOPEDIC PROBLEMS_____________________
9. PSYCHIATRIC PROBLEMS_____________________
10. CERVICAL SPINE (NECK PAIN) _________________
11. THYROID PROBLEMS _______________________
12. SUBSTANCE ABUSE ________________________
13. OTHER _________________________________

Does anyone in your family (grandparents, parents, siblings, uncle, aunts, etc.) have psychiatric or weight problems?

____

____

____

Does anyone in your family have substance abuse problems? If yes, who and what type of problem?

____

____

____

Do you have a physical problem that prevents you from being active? If yes, would you like a physical therapist to evaluate you?

____

____

____

Do you snore excessively, stop breathing while you sleep or feel tired all day?

____

____

____

Do you have nay chest pain, dizziness or joint problems when exercising? Is there any reason you should not do physical activity?

____
____
____

MEDICATIONS

Please list all previous psychiatric or weight medications you've taken, then list ALL current medications you are taking, including aspirin, Tylenol, birth control pills, hormones, vitamins, cold and sinus pills, sleeping pills, etc.

____
____
____
____
____
____
____
____
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____
____

MEDICATIONS (includes over the counter meds/supplements) YOU'RE PRESENTLY TAKING

____
____
____
____
____
____
____
____
____
____
____

MEDICAL HISTORY FORM

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.

NAME ____________________________ AGE _________________ SEX M/F

FAMILY PHYSICIAN ____

PRESENT STATUS:

1. Are you in good health at the present time to the best of your knowledge? Y/N
2. Are you under a doctor's care at the present time? Y/N
   If yes, for what? __________________________________
3. Are you taking any medication at the present time?
   Name ________________________________ Dosage ________________________
   Name ________________________________ Dosage ________________________
   Name ________________________________ Dosage ________________________
   Name ________________________________ Dosage ________________________
   Name ________________________________ Dosage ________________________

4. Any allergies to medications? Y/N
   Medication _________________________ Type of Reaction _________________
   Medication _________________________ Type of Reaction _________________
   Medication _________________________ Type of Reaction _________________

5. History of High Blood Pressure? Y/N
6. History of Diabetes? Y/N If yes, at what age? _________
7. History of Heart Attack or Chest Pain? Y/N
8. History of Swelling Feet? Y/N
9. History of Constipation (difficulty in bowel movements)? Y/N
10. History of Glaucoma? Y/N
11. History of Frequent Headaches? Y/N Migraines? Y/N
    Medication used for Headaches ______________________________

12. Gynecologic History: Pregnancies ________ Dates __________________________
    Natural Delivery/C-Section (specify) ___________________________________
    Menstrual: Onset ________________
    Duration _____________
    Are they regular? Y/N
    Pain Associated? Y/N
    Date of last menstrual period? ____________________
    Hormone Replacement Therapy Y/N
    If yes, Medication __________________________ Start Date _____________
    Birth Control Pills Y/N
    If yes, Type ________________________________ Start Date _____________
    Date of last annual exam? ________________________

13. Surgery(ies) Y/N

If yes please specify what surgery and date of that surgery.

____

____

____

____

14. Family History:

	Age	Health	Disease	Cause of Death	Overweight?
Father:					
Mother:					
Brothers:					
Sisters:					

Has any blood relative ever had any of the following:

Glaucoma	Y/N	Who________________________
Asthma	Y/N	Who________________________
Epilepsy	Y/N	Who________________________
High Blood Pressure	Y/N	Who________________________
Kidney Disease	Y/N	Who________________________
Diabetes	Y/N	Who________________________
Tuberculosis	Y/N	Who________________________
Heart Disease/Stroke	Y/N	Who________________________
Psychiatric Disorder	Y/N	Who________________________

Past Medical History (check all that apply)

__ Polio	__Measles	__Tonsillitis
__Jaundice	__Mumps	__Pleurisy
__Kidneys	__Scarlet Fever	__Liver Disease
__Lung Disease	__Whooping Cough	__Chicken Pox
__Rheumatic Fever	__Bleeding Disorder	__Nervous Breakdown
__Ulcers	__Gout	__Thyroid Disease
__Anemia	__Heart Valve Disorder	__Heart Disease
__Tuberculosis	__Gallbladder Disorder	__Psychiatric Illness
__Drug Abuse	__Eating Disorder	__Alcohol Abuse
__Pneumonia	__Malaria	__Typhoid Fever
__Cholera	__Cancer	__Blood Transfusion
__Arthritis	__Osteoporosis	__Other___________

NUTRITION EVALUATION

1. Present Weight ______ Height (no shoes) _____ Desired Weight_____
2. In what time frame would you like to be at your desired weight? ___________
3. Birth Weight _____ Weight at 20 years of age _____ Weight 1 year ago _____
4. What is the main reason for your decision to lose weight? _________________
5. When did you begin gaining excess weigh? ____________________________
6. What has been your maximum lifetime weight (non-pregnant) and when?
   ____
7. Previous diets you have followed (give dates and results of weight loss)
   ____
   ____
8. Is your spouse, fiancé or partner overweight? Y/N
9. By how much is he/she overweight? ____________________________________
10. How often do you eat out? ____
11. What restaurants do you frequent? ____________________________________
12. How often do you eat "fast foods?" ____________________________________
13. Who plans meals? _____ Cooks? ______ Shops? ______
14. Do you use a shopping list? Y/N
15. What time of day and on what day do you shop for groceries? ________________
16. Food Allergies: ____
17. Food Dislikes: ____
18. Food you crave: ____
19. Any specific time of the day or month do you crave food? _________________
20. Do you drink coffee or tea? Y/N How much daily? ______________________
21. Do you drink alcohol? Y/N How much? ____________________________
22. Do you drink cola drinks? Y/N How much daily? _______________________
23. Do you use sugar substitute? _____ Butter? _____ Margarine? _____
24. Do you awake hungry during the night? Y/N What do you do?
    ____
25. What are your worst food habits? _____________________________________
26. Snack habits? __________________What time of the day? ________________
27. What kind of snacks do you eat? _________________How much? __________
28. When you are under a stressful situation at work of family related do you tend to eat more? Y/N
    Explain____
    ____
29. Do you think you are currently undergoing a stressful situation or an emotional upset? Y/N Explain?
    ____
    ____
30. 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 quit smoking cigarettes at least 1 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 ½ pack).

____ You smoke 40 cigarettes per day (2 packs).

Typical Breakfast	Typical Lunch	Typical Dinner
________	________	________
________	________	________
________	________	________
________	________	________
________	________	________
Time eaten? ____	Time eaten? _______	Time eaten? _____
Where? _______	Where? _________	Where? ________
With Whom? ____	With Whom? ____	With whom? ____
________	________	________

Describe you energy level: ________________________________

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 a week.

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

____

____

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____

____

____

____

12 Reasons

"Why I Want to Reach My Goal Weight"

Name: ______________________ **Date:** ______________________

Before writing your reasons down, give them some thought. It is important that these 12 reasons be true personal goals and desires. They should not be generalizations or what you think would please others because they will be used as your "personal motivator."

Take a few moments from time to time each day to thoughtfully read through this list. This is called mental programming. The original of your 12 reasons list is retained in your medical file. You will be given a copy to carry at all times. We suggest that you also transfer your list onto a 3 x 5 card which may be more convenient.

Make a promise to yourself now: "I will read the entire card whenever I am confronted with a difficult food situation." Reading the list will clearly reinforce your personal commitment to take control of your health and self-esteem.

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________
9. ______________________
10. ______________________
11. ______________________
12. ______________________

Information Sheet

PATIENT NAME____**AGE**_____**SEX**_____
ADDRESS____**PHONE**_______________
CITY_____________________________________ **STATE**_________**ZIP**_____________
SS#______________________________**BIRTHDATE**_____________________________
EMPLOYER_____________________________**OCCUPATION**____________________
WORK PHONE #____________________________
CAN WE CALL YOU AT WORK? _______**OR HOME?**__________________________
MARITAL STATUS _______**SPOUSE/PARENT NAME**__________________________
PERSON TO NOTIFY IN CASE OF EMERGENCY_____________________________
EMERGENCY CONTACT PHONE NUMBER__________________________________

PLEASE NOTE:
ALL CHARGES ARE DUE WHEN SERVICES ARE RENDERED REGARDLESS OF INSURANCE COVERAGE. In the event that we may need to assist you in being reimbursed, please supply the following information in detail:

PRIMARY INSURANCE_________________________**POLICY HOLDER**__________
POLICY NUMBER______________________________ **GROUP NUMBER**___________
SECONDARY INSURANCE______________________**POLICY HOLDER**__________
POLICY NUMBER_______________________________**GROUP NUMBER**__________

MAJOR CREDIT CARD (MC or V)# ___________________________**EXP**_________
DRIVERS LICENSE #_______________________________________**STATE**__________

Payment for service is due at the time service is rendered regardless of insurance coverage. We accept cash, checks, Mastercard or Visa. We will suppl;y you with all the necessary forms to submit to your insurance company for reimbursement. Rember that your insurance is a contract between you and your insurance company. We are not a party to that contract. Any unpaid balances after ninety days will be charged to your credit/debit card account unless otherwise arranged in writing with our office. In the unlikely event that this amount is placed for collection, you will be responsible, in addition to the unpaid balance of your bill, for all costs and collections.
I hereby assign all medical benefits to include major medical benefits to which I am entitled to the Center for Psychiatry and Weight Management. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance.I hereby authorize to release all information necessary to secure payments.

SIGNED____**DATE**___________

Please put your email address below if you would like to get our periodic office newsletters.

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