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. _____

Welcome to WeightLossNYC™!

Patient Information Form

Name: (Last)_____(First)_____(MI)___

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____Alternate Phone: _____

Email: _____

Birth Date: _____Insurance company: _____

Age: _____ Sex: M F

Employer: _____ Occupation: _____

Work Phone: _____

How did you learn about us? (Please choose one)

1. Referral (name) _____

2. Noticed Sign [ ] Walk-in [ ] Flyer [ ] Other_____

3. Google [ ] Yahoo [ ] Other site _____

If found on the internet, what words or phrases did you search for? _____

In Case of Emergency:

Name: _____Relationship: _____ Phone: _____

Patient's Spouse: _____ Phone: _____

Family Physician: _____ Phone: _____

Financial Policy:

Thank you for selecting Dr. Aron for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made.

I have read and understand all of the above and have agreed to these statements.

_____ _____

Patient's Signature Date

Medical History Form

Have you ever been in a medical weight loss program? Yes No

If Yes: Last visit _____ Dr's Name & Phone _____

Medications prescribed _____

1. Are you in good health at the present time to the best of your knowledge? Yes No

2. Are you under a doctor's care at the present time? Yes No
   If yes, for what? _____

3. Are you taking any medications or supplements at the present time? Yes No
   What: _____ Dosages: _____
   What: _____ Dosages: _____
   What: _____ Dosages: _____
   What: _____ Dosages: _____
   What: _____ Dosages: _____
   What: _____ Dosages: _____

4. Any allergies to any medications? Yes No
   _____

5. History of High Blood Pressure? Yes No

6. History of Diabetes? (If yes, at what age: ____) Yes No

7. History of Heart Attack or Chest Pain? Yes No

8. History of Swelling Feet Yes No

9. History of Frequent Headaches or Migraines Yes No
   If so, Medications for Headaches: _____

10. History of Constipation (difficulty in bowel movements)? Yes No

11. History of Glaucoma? Yes No

12. Gynecologic History:
    Pregnancies: Number: _____ Last one: _____Last menstrual period: _____

    Natural Delivery or C-Section (specify): _____

    Hormone Replacement Therapy: Yes No
    What: _____
    Birth Control Pills: Yes No
    Type: _____

13. Serious Injuries: Yes No
    Specify: _____ Date: _____

14. Any Surgery: Yes No

Specify: _____ Date: ____
Specify: _____ Date: ____

15. Family History:

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

Has any blood relative ever had any of the following:

Glaucoma: Yes No Who: _____
Asthma: Yes No Who: _____
Epilepsy: Yes No Who: _____
High Blood Pressure Yes No Who: _____
Kidney Disease: Yes No Who: _____
Diabetes: Yes No Who: _____
Tuberculosis: Yes No Who: _____
Psychiatric Disorder Yes No Who: _____
Heart Disease/Stroke Yes No 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 one year ago: _____

4. What is the main reason for your decision to lose weight? _____

_____

5. When did you begin gaining excess weight? (Give reasons, if known

_____

6. What has been your maximum weight (non-pregnant) and when?_____

7. Previous diets you have followed: Give dates and results of your weight loss:

_____ _____

_____ _____

8. Is your spouse, fiancee or partner overweight? Yes No If so, by how much _____ lbs

10. How often do you dine 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? Yes No

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? Yes No How much daily? _____

21. Do you drink cola drinks? Yes No How much daily? _____

22. Do you drink alcohol? Yes No

What? _____ How much? _____ Frequency? Daily / Weekly / Monthly

23. Do you use (circle any) Sugar / Sugar substitute _____ / Butter / Margarine

24. Do you awaken hungry during the night? Yes No

What do you do? _____

25. What are your worst food habits? _____

_____

26. Snack Habits:

What? _____ How much? _____ When? _____

_____ _____ _____

27. When you are under a stressful situation at work or family related, do you tend to eat more? Explain:

28. Do you thing you are currently undergoing a stressful situation or an emotional upset? Explain:

29. Have you ever smoked? Yes No If you quit, when _____

You presently smoke __ 20 cigarettes/day (1 pack) __ 30 /day (1-1/2 packs) __ 40 /day (2 packs).

30.

Typical Breakfast	Typical Lunch	Typical Dinner
Time eaten: _____	Time eaten: _____	Time eaten: _____
Where: _____	Where: _____	Where: _____
With whom: _____	With whom: _____	With whom: _____

31. Describe your usual energy level: _____

32. 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 sports activities such as weekend golf, tennis, etc.
____ Heavy activity—consistent lifting, stair climbing, heavy construction, etc.,
or regular participation in jogging etc 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.

33. Behavior style: **(answer only one)**
____ You are always calm and easygoing.
____ You are usually calm and easygoing.
____ You are sometimes calm with frequent impatience.
____ You are seldom calm and persistently driving for advancement.
____ You are never calm and have overwhelming ambition.
____ You are hard-driving and can never relax.

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

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.

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Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____ Date of Birth _____

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. This includes, but is not limited to:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and healthcare operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclosure protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with written authorization.
- My individual rights with respect to protected health information and brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to secretary of HHS if I believe that my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. If changes occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Signature: _____ Date: _____

Relationship to Patient (If signed by a representative of patient): _____

Weight Loss Program Consent Form

I _____ authorize OKSANA ARON M.D. and whomever they designate as their assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Date: _____ **Patient:** _____

(Or person with authority to consent for patient)