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
15. Family History:

<table>
<thead>
<tr>
<th>Father</th>
<th>Age</th>
<th>Health</th>
<th>Disease</th>
<th>Cause of Death</th>
<th>Overweight?</th>
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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?” __________________________________________


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


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:


________________________________________  __________________________________________

________________________________________  __________________________________________

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.
Advanced Medical & Alternative Care, P.C
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Brooklyn, N.Y 11209
(718)491-5525
Fax: (718)491-1520

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)