

Institute for Weight Management

Patient Information Form

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

Name you prefer to be called: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Beeper/Cellular: _____

Birth date: _____ Age: _____ Sex: M F

Country of Birth: _____ Country of Parents' Birth: _____

Education: Elementary High School/Technical School 2-yr College 4-yr College Graduate School
(Circle the highest level achieved)

Email address: _____

Employment Information:

Patient Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work phone No: _____ Ext. _____

Social Security: _____ Drivers License: _____

In Case of Emergency:

Name: _____ Relationship: _____ Phone: _____

Patient's Spouse: _____ Phone: _____

Family Physician: _____ Phone: _____

Referred by: _____

Financial Policy:

Thank you for selecting Dr. Anjana Chhabra, MD 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 hereby assign all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered or treatments provided by Dr. Anjana Chhabra regardless of her managed care network participation status.

I hereby authorize Dr. Anjana Chhabra to (1) release any information necessary to insurance carriers regarding my illness and treatment; (2) process insurance claims generated in the course of treatment; (3) allow a photocopy of my signature to be used to process insurance claims.

I have read and understand all of the above and have agreed to these statements. A Photocopy of this assignment is to be considered as valid as the original.

Patient's Signature

Date

Institute for Weight Management
Medical History Form

Name: _____ Age: _____ Sex: M F

Family Physician: _____ Phone: _____

Present Status:

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 at the present time? Yes No
What: _____ Dosages: _____
What: _____ Dosages: _____
4. Any allergies to any medications? Yes No

5. History of High Blood Pressure? Yes No
6. History of Diabetes? Yes No
At what age: _____
7. History of Heart Attack or Chest Pain? Yes No
8. History of Swelling Feet Yes No
9. History of Frequent Headaches? Yes No
Migraines? Yes No Medications for Headaches: _____
10. History of Sleep Apnea Yes No
11. History of Glaucoma? Yes No
12. Gynecologic History:
Pregnancies: Number: _____ Dates: _____
Natural Delivery or C-Section (specify): _____
Menstrual: Onset: _____
Duration: _____
Are they regular: Yes No
Pain associated: Yes No
Last menstrual period: _____
Hormone Replacement Therapy: Yes No
What: _____
Birth Control Pills: Yes No
Type: _____
Last Check Up: _____
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
_____ Sleep Apnea	_____ 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 lifetime weight (non-pregnant) and when? _____
7. Previous diets you have followed: _____ Give dates and results of your weight loss: _____

8. Is your spouse, fiancée or partner overweight? Yes No
9. By how much is he or 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? 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? _____ Weekly? _____
23. Do you use a 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. 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 have quit smoking cigarettes at least one 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 (1-1/2 packs).
- You smoke 40 cigarettes per 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 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 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: _____

INFORMED CONSENT

We Want You to Know

When you decide to learn more about managing your weight, you took an important step toward improving your health. The health professional who is advising you can help you develop comprehensive weight management skills while you lose a meaningful amount of weight. The calorie deficit and protein-controlled diets (including liquid formulas) were developed over 25 years ago for weight reduction. They are used with patients who are overweight and who may have significant medical problems related to obesity. Such problems may include hypertension, coronary disease, diabetes, lung, joint or bone disease, and the need for non emergency surgery, these methods of weight reduction have been utilized in hundreds of clinics in the United States. They have been described and evaluated in many professional medical journals since 1974.

Your Role

Your success will depend upon your commitment to understanding and fulfilling your obligations in a course of treatment. It is important that you be willing to:

- Provide honest and complete answers to questions about your health, weight problem, and eating activity and lifestyle patterns so your health care professional can better understand how to help you.
- Devote the time needed to complete and comply with the course of treatment your health professional has outlined for you, including assessment, treatment, and maintenance phase.
- Work with your health care professional and others who may participate in helping you manage your weight loss, including keeping a daily diary, attending your sessions regularly if appropriate, and following your diet and exercise prescription.
- Allow your health care professional to share information with your personal physician.
- Make and keep follow-up appointments with the physician and have any blood tests taken or any other diagnostic measures made which your physician may deem necessary during your course of treatment.
- Follow your exercise program within guidelines given to you by your healthcare professional and your physician.
- It is vitally important for you to advise the clinic staff of ANY concerns, problems, symptoms, or questions even if you may think it is not terribly important, so the physician can determine if you should be seen more often. Keeping the clinic informed of any questions or symptoms you have, affords the best chance of intervening before the problem becomes serious.

If you do not have a personal physician, you must agree to find one before you and your healthcare professional begin working together. Your healthcare professional can assist you in this process if you like.

Potential Benefits

Medically-significant weight loss (usually about 10 percent of initial weight, or as an example, losing 20lbs. starting weight) can:

- Lower blood pressure , reducing the risk of hypertension
- Lower cholesterol, reducing the risk of heart and vascular disease
- Lower blood sugar, reducing the risk of diabetes

If you are taking medication for one or more of these conditions, dosage may need to be adjusted as your overall health improves. You agree to see your physician as needed to have your need for these medications reassessed. Your healthcare professional will share your results with your physician on a regular basis do the physician is informed about your progress.

Other benefits may also be obtained. Increasing activity level can favorably affect the above conditions and has the additional benefit of helping you sustain weight loss. Weight loss and increased activity provides important physiological and social benefits, as well.

Possible Side Effects

The possibility always exist in medicine that the combination of any significant disease with methods employed for its treatment may lead to previously unobserved or unexpected ill effects, including death. Should one or more of these conditions occur, additional medical or surgical treatment may be necessary, in addition, it is conceivable other side effects could occur which have not been observed to date.

Reduce weight. When you reduce the number of calories you eat to a level lower than the number of calories your body uses in a day, you lose weight. In addition, your body makes some other adjustment in psychology. Some of these are responsible, and some participant, for rapid improvement in blood pressure and blood sugar, other adjustments may be experienced as temporary side effects or discomforts. These may include an initial loss of body fluid through increased urination, monitory dizziness, a reduced metabolic rate or metabolism, change sensitivity to cold, a slow heart rate, dry skin, fatigue, diarrhea or constipation, bad breath, muscle cramps, a change in menstrual pattern, dry and brittle hair or hair loss. These responses are temporary and resolve when calories are increased after the period of weight loss.

Reduce potassium level. The calorie level you will be consuming is 800 or more calories per day and it is important that you consume the calories which have been prescribed in your diet to minimize side effects. Failure to consume all of the food and fluids and nutritional supplements or taking a diuretic medication (water pill) may cause low blood potassium levels or deficiency in other key nutrients. Low potassium level can cause serious heart irregularity. When someone has been on a reduced calorie diet, a rapid increase in calorie intake, especially overeating or binge eating, can be associated with bloating, fluid retention, disturbance in salt or mineral balance, or gall bladder attacks and abdominal pain. For these reasons, following the diet carefully and following the gradual increase in calories after weight loss is essential.

Gallstones. Overweight people develop gallstones at a rate hire than normal weight individuals. The occurrence of symptomatic gallstones (pain, diagnosed stones and/or surgery in individuals 30% or more over desirable body weight) 50lbs. or more overweight, about one-half that rate, or 1 in 200 annually. It is possible to have gallstones and not know it. One study of individuals entering a weight loss program showed that as many as 1 in 10 had “silent” gallstones at the onset. As body weight and age increase, so do the chances of developing gallstones. These chances double for women, women using estrogen and smokers. Losing weight- especially rapidly – may increase the chances of developing stones or sludge and/or increasing the size of

existing stones within the gallbladder. Should any symptoms develop (the most common are fever, nausea, and a cramping pain in the right upper abdominal or if you know or suspect that you may already have gallstones.), let your physician and healthcare professional know immediately. Gallbladder problems may require medication or surgery to remove the gallbladder, and, less commonly, maybe associated with more serious complications of inflammation of the pancreas or even death. A drug (Actigall) is currently available which may help prevent gallstones formation during rapid weight loss. You may wish to discuss Atigall with your primary care or weight management physician for more information.

Pancreatitis. Pancreatitis or an infection in the bile ducts maybe associated with the presence of gallstones and the development of slush or obstruction in the bile ducts. The symptoms of pancreatitis include pain in the left upper abdominal area, nausea, and fever. Pancreatitis maybe precipitated by binge eating or consuming a large meal after a period of dieting. Also associated with pancreatitis are long term abuse of alcohol and the use of certain medications and increased age. Pancreatitis may require surgery and maybe associated with more serious complications and death.

Pregnancy. If you become pregnant, report this to your healthcare professional and physician immediately. Your diet must be changed promptly to avoid further weight loss because a restricted diet could be damaging for a developing fetus. You must take precautions to avoid becoming pregnant during the course of weight loss.

Bing eating disorder. Binge eating disorder is defined as habitual, uncontrolled consumption of a large amount of food in a short period of time. Participation and a calorically restricted diet have been seen in one study to increase binge eating episodes temporarily. Several other studies demonstrate reduced episodes of binge eating following a calorie deficit and portion-controlled diet. Extended binge eating episodes are associated with weight gain.

The Risk of Weight Regain

Obesity is a chronic condition, and the majority of overweight individuals who lose weight have a tendency to regain all or some over time. Factors which favor maintaining a reduced body weight include regular physical activity, adherence to a restricted calorie, low fat diet, and planning a strategy for coping with weight regain before it occurs. Successful treatment may take months or even years. Medical studies of calorie deficit/portioned-controlled diets (including modified fasting) have shown varying results for percentage of patients who maintain weight loss. In some studies, the percentage has been fewer than 5% of the patients after five years. A group of patients who have been followed for 3 years show that patients have maintained about one half of initial weight loss. Additionally, if you have had fluctuations in your weight in the past, it may be more difficult to maintain the weight you lose during and after this program. A recently published medical study indicated people whose body weight fluctuates greatly or often has a higher risk of heart disease and death compared with persons of relatively stable body weight, and such weight fluctuations may play a role in the development of chronic diseases.

Sudden Death. Patients with morbid obesity, particularly those with serious hypertension, coronary artery disease, or diabetes mellitus, have a statistically higher chance of suffering sudden death when compared to normal weight people without such medical problems. Rare instances of sudden death have occurred while obese patients were undergoing medically supervised weight reduction, though no cause and effect relationship with the diet has been established. The possibility cannot be excluded that some undefined or unknown factor in the treatment program could increase this risk in an already medically vulnerable patient.

Your Rights and Confidentiality

You have the right to leave treatment at any time without penalty, although you do have a responsibility to make sure the physician is able to assume medical care for you after you leave treatment.

By signing this Informed Consent, you state: I understand the information about my treatment in the weight management program offered by the clinic identified below is shared, from time to time, with obesity researchers, medical scientist, and developers of weight management treatment. So research, science and the weight management industry may learn and benefit from my treatment and the treatment of others, I give permission for data regarding my treatment to be entered into a national database. I understand that strict confidentiality for identities and individual records of patients in the database will be maintained. I also give local and national program staff permission to contact me by mail or telephone after my initial period of treatment to obtain information about my health and weight status. Should the results of my treatment or any aspect of it be published, all reasonable precautions will be taken to protect my anonymity.

I, the undersigned, have reviewed this information with my health care professional or my physician, and have had the opportunity to ask questions and have them answered to my satisfaction.

Participant Signature

Date

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to, the proposed program and have answered any questions posed by the patient. I believe the patient/relative/guardian fully understands what I have explained and answered.

Physician Signature

Date

I hereby received a copy of this signed consent form.

Participants Initials

Date

Institute for Weight Management

THE CARBOHYDRATE ADDICT'S TEST

INSTRUCTIONS

- 1). Please take the Carbohydrate Addiction Test alone, and complete in one sitting.
 - 2). For each of the questions, answer yes if it usually applies to you and no if it usually does not. But answer every question.
 - 3). Answer as if you were not on a diet or worrying about calorie consumption or about your weight.
 - 4). If you are unsure of an answer, take time to think it through. Don't worry about defending or explaining yourself. Answer candidly about your tendencies or impulses to eat.
 - 5) This test is based on statistical research in the area of eating patterns. It is designed to compensate for guesses. So don't be overly concerned about the right answer. In the long run guessing will not influence the accuracy of the test.
- 6) Answer each question as if it stands by itself—don't try to link it to any other question. Try not to be concerned about how many yes or no answers you mark. Just answer as honestly as you can without concern for your score.*

1. _____ I get tired and/or hungry in the midafternoon.
2. _____ About an hour or two after eating a full meal that includes dessert, I want more of the dessert.
3. _____ It is harder to control my eating for the rest of the day if I have a breakfast containing carbohydrates, than it would be if I had only coffee or nothing at all.
4. _____ When I want to lose weight I find it is easier not to eat for most of the day than to try to eat several small diet meals.
5. _____ Once I start eating sweets, starches, or snack foods, I often have a difficult time stopping.
6. _____ I would rather have an ordinary meal that included dessert than a gourmet meal that did not include dessert.
7. _____ After finishing a full meal I sometimes feel as if I could go back and eat the whole meal again.
8. _____ A meal of only meat and vegetables leaves me feeling unsatisfied.
9. _____ If I am feeling down, a snack of cake or cookies makes me feel better.
10. _____ If potatoes, bread, pasta or dessert are on the table I will often skip eating vegetables or salad.
11. _____ I get a sleepy, almost "drugged" feeling after eating a large meal containing bread or pasta or potatoes and dessert, whereas I feel more energetic after a meal of only meat and salad.
12. _____ When I am not eating, the sight of other people eating is sometimes irritating to me.

13. _____ I sometimes have a hard time going to sleep without a bedtime snack.
14. _____ At times I awaken in the middle of the night and can't go back to sleep unless I eat something.
15. _____ Now and then I think I am a secret eater .
16. _____ Before going to dinner at a friend's house, I will sometimes eat something in case dinner is delayed.
17. _____ At a restaurant, I almost always eat too much bread, even before the meal is served.

THE CARBOHYDRATE ADDICT'S TEST

Doubtful Addiction	(21 or less)
Mild Carbohydrate Addiction	(22-30)
Moderate Carbohydrate Addiction	(31-44)
Severe Carbohydrate Addiction	(45-60)

FOR EACH YES GIVE FOLL. POINTS

1. _____ 4

2. _____ 5

3. _____ 3

4. _____ 4

5. _____ 3

6. _____ 3

7. _____ 5

8. _____ 3

9. _____ 3

10. _____ 3

11. _____ 4

12. _____ 4

13. _____ 3

14. _____ 3

15. _____ 5

16. _____ 3

17. _____ 2

Total Possible Score 60

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. _____



Consent for Pictures and Success Story

Name: _____

D.O.B. _____

- _____ I give permission to Dr. Chhabra, the staff of The Institute for Weight Management to publish both my before and after pictures (in partial or full) to keep in my chart records.

- _____ I give permission to Dr. Chhabra, the staff of The Institute for Weight Management to publish my before and after pictures (in partial or full) in their office Scrap Book, Website, and in their E-news letter.

- _____ I give permission to Dr. Chhabra, the staff of The Institute for Weight Management to publish my success story in their E-News Letter.

Signature X _____

Date: _____

Cancellation Policy/No-Show Policy for Doctor Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book. Leave a message on our machine if the office is closed; we check our messages daily.

If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty-five dollar (\$25) fee; this will NOT be covered by your insurance company

Print Name

Patient Signature

____/____/____
Date

Acknowledgement of Receipt of Notice of Privacy Practices

THE INSTITUTE FOR WEIGHT MANAGEMENT reserves the right to modify the privacy practices outlined in the notice.

Signature: x _____ Date _____

I have read a copy of the Notice of Privacy Practices for
THE INSTITUTE FOR WEIGHT MANAGEMENT

Name of Patient:

Signature of Patient:

Date:

Signature of Patient Representative _____
(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient _____

Please indicate name and relationship of person(s) that we can provide your medical information to in case of emergency.

Name: _____

Relationship: _____

Name: _____

Relationship: _____