



**Patient Information**

Patient Name:(Last)\_\_\_\_\_ (First)\_\_\_\_\_ (MI)\_\_\_\_\_

Patient Address: \_\_\_\_\_ City \_\_\_\_\_

State:\_\_\_\_\_ Zip \_\_\_\_\_

Home Phone:\_\_\_\_\_ Cell:\_\_\_\_\_ Email:\_\_\_\_\_

Birth date:\_\_\_\_\_ Age:\_\_\_\_\_ Sex: M F

Insurance Provider (additional testing may be covered by insurance):\_\_\_\_\_ HMO: Y N

**In Case of Emergency:**

Name:\_\_\_\_\_

Relationship:\_\_\_\_\_ Phone:\_\_\_\_\_

Referred by:\_\_\_\_\_

**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. Name of Doctor:\_\_\_\_\_ Doctor's Phone #:\_\_\_\_\_

**Financial Policy:**

Thank you for selecting Valentine Weight Loss & Wellness Center for your health/weight loss needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and financial policy. Please be advised that payments for all services will be due at the time services are rendered, unless prior arrangements have been made. Insurance may cover some of the additional testing that we offer but generally does not cover weight loss. I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs. I have read and understand all of the above and have agreed to these statements.

Signature:\_\_\_\_\_ Date:\_\_\_\_\_

# VALENTINE WEIGHT LOSS & WELLNESS CENTER

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Past Health History Complete to the best of your knowledge

		Family	Personal			Family	Personal			Family	Personal
ADD				Dizzy Spells				Liver Disease			
ADHD				Drug Abuse				Lung Disease			
Alcohol Abuse				Eating Disorder				Migraines			
Anemia				Epilepsy				Mood Swings			
Arthritis				Emphysema				Nervousness			
Asthma				Fainting Spells				Obesity			
Bleeding Disorder				Fatigue				Palpitations			
Bloody Stool				Fibromyalgia				Psychiatric Illness			
Bronchitis				Frequent Urination				Rashes			
Cancer				Gallbladder Disorder				Seizures			
Celiac Disease				Glaucoma				Shortness of Breath			
Chest Pain				Headaches				Stroke			
COPD				Heart Disease				Thyroid Disease			
Constipation				High Cholesterol				Prior Diet Pill Use			
Convulsions				Hypertension				<i>(LIST ANY OTHER HEALTH ISSUES)</i>			
Depression				Insomnia				_____			
Diabetes				Irregular Pulse				_____			
Diarrhea				Kidney Disease				_____			

Comments/Other: \_\_\_\_\_

### Major Surgeries

Have you had any major surgeries    \_\_\_ YES \_\_\_ NO

If yes, please explain:


### Medication Allergies

Medication Name	Reaction

### Prescribed Medications & Over-the-Counter drugs, dietary supplements (including vitamins, inhalers, etc.)

Medication Name	Strength	Frequency

# VALENTINE WEIGHT LOSS & WELLNESS CENTER DIETARY SURVEY

This questionnaire is the most important from you will complete and will be used as part of the criterion for your acceptance into our program.

(PLEASE CHECK EVERY BOX THAT APPLIES - YOU MAY HAVE TO CHECK MORE THAN ONE BOX PER QUESTION)

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

a) **What is your martial status?**

- |   |  |
|---|--|
| <input type="checkbox"/> never been married | <input type="checkbox"/> separated       |
| <input type="checkbox"/> single             | <input type="checkbox"/> remarried       |
| <input type="checkbox"/> divorced           | <input type="checkbox"/> engaged         |
| <input type="checkbox"/> widowed            | <input type="checkbox"/> deceased spouse |
| <input type="checkbox"/> married            | <input type="checkbox"/> life partner    |

other (explain): \_\_\_\_\_

b) **Do you have children and if so how many?**

- |   |   |
|---|---|
| <input type="checkbox"/> no offspring                       | <input type="checkbox"/> One step child                           |
| <input type="checkbox"/> one child                          | <input type="checkbox"/> multiple step children( how many): _____ |
| <input type="checkbox"/> multiple children( how many) _____ |   |

c) **Have there been recent changes in your home (circle one) YES NO**

d) **What are your sleep patterns**

- |  |   |
|--|---|
| <input type="checkbox"/> sleep walks           | <input type="checkbox"/> unusual sleep patterns |
| <input type="checkbox"/> have sleep apnea      | <input type="checkbox"/> wakes up at night      |
| <input type="checkbox"/> complains of insomnia | <input type="checkbox"/> uses sleep aids        |
|  | <input type="checkbox"/> no sleeping issues     |

e) **Please list any contributing stress factors**

- |   |  |
|---|--|
| <input type="checkbox"/> no stress related issues         | <input type="checkbox"/> illness in the family         |
| <input type="checkbox"/> out of work                      | <input type="checkbox"/> martial difficulty            |
| <input type="checkbox"/> adult family members in the home | <input type="checkbox"/> psychiatric illness in family |
| <input type="checkbox"/> alcoholism in the family         | <input type="checkbox"/> recent death in family        |
| <input type="checkbox"/> children in the home             | <input type="checkbox"/> recent trauma                 |
| <input type="checkbox"/> drugs in the home                | <input type="checkbox"/> stress at work                |
| <input type="checkbox"/> drug use in family               | <input type="checkbox"/> recent changes in home        |
| <input type="checkbox"/> financial difficulties           | <input type="checkbox"/> other: _____                  |

e1) What is your occupation/employment: \_\_\_\_\_

f) **What is your education level?**

- |   |   |
|---|---|
| <input type="checkbox"/> elementary school    | <input type="checkbox"/> graduate degree        |
| <input type="checkbox"/> high school diploma  | <input type="checkbox"/> completed some college |
| <input type="checkbox"/> undergraduate degree | <input type="checkbox"/> unknown                |

g) **Do you or have you ever smoked cigarettes regularly?**

- |   |   |
|---|---|
| <input type="checkbox"/> no history of using cigarettes               | <input type="checkbox"/> I use to smoke for ____ years              |
| <input type="checkbox"/> I smoke ____ pack(s) per day                 | <input type="checkbox"/> I stoped smoking cigarettes ____ years ago |
| <input type="checkbox"/> I have currently been smoking for ____ years |   |

h) **Do you drink caffeine beverages**

- |   |  |
|---|--|
| <input type="checkbox"/> I do not drink caffeine          | <input type="checkbox"/> drink caffeine moderately             |
| <input type="checkbox"/> drink minimal amount of caffeine | <input type="checkbox"/> drink caffeine heavily                |
| <input type="checkbox"/> drink caffeine occasionally      | <input type="checkbox"/> I drink ____ cups of caffeine per day |
| <input type="checkbox"/> drink caffeine daily             |  |

i) **Do you drink or use alcohol (beer/wine/hard liquor)**

- |   |  |
|---|--|
| <input type="checkbox"/> never drink alcohol              | <input type="checkbox"/> drink moderate amounts of alcohol |
| <input type="checkbox"/> does not currently drink alcohol | <input type="checkbox"/> drink heavy amounts of alcohol    |
| <input type="checkbox"/> drink occasionally               | <input type="checkbox"/> I drink ____ days per week        |

(PLEASE CHECK EVERY BOX THAT APPLIES - YOU MAY HAVE TO CHECK MORE THAN ONE BOX PER QUESTION)

j) What is the main reason you decided to lose weight?

- |  |   |
|--|---|
| <input type="checkbox"/> Self Esteem           | <input type="checkbox"/> Overall Health   |
| <input type="checkbox"/> Role Model for Family | <input type="checkbox"/> Appearance       |
| <input type="checkbox"/> Relationship          | <input type="checkbox"/> Medical Problems |
| <input type="checkbox"/> Other                 | <input type="checkbox"/> Feel Better      |

k) When did you begin gaining weight?

- approximate date: \_\_\_\_\_
- |  |  |
|--|--|
| <input type="checkbox"/> since childhood | <input type="checkbox"/> after children        |
| <input type="checkbox"/> after sickness  | <input type="checkbox"/> after stressful event |
- other (explain): \_\_\_\_\_

l) What do you think is the main cause of your weight problems?

- |   |   |
|---|---|
| <input type="checkbox"/> lack of will power   | <input type="checkbox"/> medical problems                   |
| <input type="checkbox"/> peer/family pressure | <input type="checkbox"/> lack of knowledge of healthy foods |
| <input type="checkbox"/> lack of motivation   | <input type="checkbox"/> lack of exercise                   |
- other (explain): \_\_\_\_\_

m) Describe your previous attempts at weight loss or previous diets you have tried

- |  |   |
|--|---|
| <input type="checkbox"/> tried on your own | <input type="checkbox"/> blood type diet    |
| <input type="checkbox"/> low carb diet     | <input type="checkbox"/> weight watchers    |
| <input type="checkbox"/> the zone          | <input type="checkbox"/> Mediterranean diet |
| <input type="checkbox"/> south beach       | <input type="checkbox"/> nutri-system       |
- other (explain): \_\_\_\_\_

n) How many times do you dine out per week? \_\_\_\_\_

o) Have you exercised in the last month? YES or NO (Circle one)

p) How many times do you exercise per week? \_\_\_\_\_

q) What do you do for exercise?

- |   |   |
|---|---|
| <input type="checkbox"/> I do not exercise  | <input type="checkbox"/> weights          |
| <input type="checkbox"/> jog                | <input type="checkbox"/> personal trainer |
| <input type="checkbox"/> walking            | <input type="checkbox"/> bike             |
| <input type="checkbox"/> treadmill          | <input type="checkbox"/> swim             |
| <input type="checkbox"/> elliptical trainer | <input type="checkbox"/> aerobics         |
|   | <input type="checkbox"/> dance classes    |
- other (explain): \_\_\_\_\_

r) What is the length time spent exercising per session

- |                                 |                                      |
|---------------------------------|--------------------------------------|
| <input type="checkbox"/> 15 min | <input type="checkbox"/> 45 min      |
| <input type="checkbox"/> 20 min | <input type="checkbox"/> 60 min      |
| <input type="checkbox"/> 30 min | <input type="checkbox"/> over 60 min |

t) What foods do you crave?

- |   |  |
|---|--|
| <input type="checkbox"/> vegetables                       | <input type="checkbox"/> beef              |
| <input type="checkbox"/> carbs                            | <input type="checkbox"/> pork              |
| <input type="checkbox"/> candy/sweets                     | <input type="checkbox"/> fish              |
| <input type="checkbox"/> breads                           | <input type="checkbox"/> high fiber foods  |
| <input type="checkbox"/> pastries, cakes, donuts, cookies | <input type="checkbox"/> soda (non diet)   |
| <input type="checkbox"/> fast food                        | <input type="checkbox"/> diet soda         |
| <input type="checkbox"/> fried food                       | <input type="checkbox"/> juice/punch       |
| <input type="checkbox"/> chicken                          | <input type="checkbox"/> chips             |
| <input type="checkbox"/> white rice                       | <input type="checkbox"/> ice cream         |
| <input type="checkbox"/> tortillas                        | <input type="checkbox"/> beer/wine/alcohol |
- other (explain): \_\_\_\_\_

(PLEASE CHECK EVERY BOX THAT APPLIES - YOU MAY HAVE TO CHECK MORE THAN ONE BOX PER QUESTION)

**u) What do you eat to snack and when?**

When do you snack \_\_\_\_\_

- |   |  |
|---|--|
| <input type="checkbox"/> vegetables                       | <input type="checkbox"/> beef              |
| <input type="checkbox"/> carbs                            | <input type="checkbox"/> pork              |
| <input type="checkbox"/> candy/sweets                     | <input type="checkbox"/> fish              |
| <input type="checkbox"/> breads                           | <input type="checkbox"/> high fiber foods  |
| <input type="checkbox"/> pastries, cakes, donuts, cookies | <input type="checkbox"/> soda (non diet)   |
| <input type="checkbox"/> fast food                        | <input type="checkbox"/> diet soda         |
| <input type="checkbox"/> fried food                       | <input type="checkbox"/> juice/punch       |
| <input type="checkbox"/> chicken                          | <input type="checkbox"/> chips             |
| <input type="checkbox"/> white rice                       | <input type="checkbox"/> ice cream         |
| <input type="checkbox"/> tortillas                        | <input type="checkbox"/> beer/wine/alcohol |
| <input type="checkbox"/> other (explain): _____           |  |

**v) What do you feel will be your obstacle(s) to successful weight loss?**

- |   |  |
|---|--|
| <input type="checkbox"/> Not eating healthy                   | <input type="checkbox"/> social activities/parties |
| <input type="checkbox"/> skipping meals                       | <input type="checkbox"/> alcohol/beer/wine         |
| <input type="checkbox"/> taste of healthy food                | <input type="checkbox"/> soda /juice /punch        |
| <input type="checkbox"/> a need to finish everything on plate | <input type="checkbox"/> late night snacks         |
| <input type="checkbox"/> peer/family pressure                 | <input type="checkbox"/> financial issues          |
| <input type="checkbox"/> other (explain): _____               |  |

**x) What is your typical breakfast and what time to you typically eat breakfast?**

- Time: \_\_\_\_\_
- |   |  |
|---|--|
| <input type="checkbox"/> skip breakfast         | <input type="checkbox"/> breads                |
| <input type="checkbox"/> cereal                 | <input type="checkbox"/> pastries/cakes/donuts |
| <input type="checkbox"/> eggs                   | <input type="checkbox"/> fast food             |
| <input type="checkbox"/> breakfast meat         | <input type="checkbox"/> restaurant food       |
| <input type="checkbox"/> coffee                 | <input type="checkbox"/> frozen meal           |
| <input type="checkbox"/> other (explain): _____ |  |

**y) What is your typical lunch and what time do you typically eat lunch?**

- Time: \_\_\_\_\_
- |   |  |
|---|--|
| <input type="checkbox"/> skip lunch             | <input type="checkbox"/> yogurt          |
| <input type="checkbox"/> sandwich               | <input type="checkbox"/> energy drink    |
| <input type="checkbox"/> soup                   | <input type="checkbox"/> protein drink   |
| <input type="checkbox"/> salad                  | <input type="checkbox"/> protein bar     |
| <input type="checkbox"/> frozen meal            | <input type="checkbox"/> fast food       |
| <input type="checkbox"/> fruit                  | <input type="checkbox"/> restaurant food |
| <input type="checkbox"/> other (explain): _____ |  |

**z) What is your typical dinner and what time do you typically eat dinner?**

- Time: \_\_\_\_\_
- |   |  |
|---|--|
| <input type="checkbox"/> skip dinner            | <input type="checkbox"/> rice/potatoes   |
| <input type="checkbox"/> home cooked meal       | <input type="checkbox"/> vegetables      |
| <input type="checkbox"/> frozen meal            | <input type="checkbox"/> fast food       |
| <input type="checkbox"/> salad                  | <input type="checkbox"/> restaurant food |
| <input type="checkbox"/> sandwich               | <input type="checkbox"/> protein shake   |
| <input type="checkbox"/> meats                  | <input type="checkbox"/> protein bar     |
| <input type="checkbox"/> other (explain): _____ |  |

**Z1) Please add any additional comments you think would be helpful to the doctor?**

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*Valentine*  
WEIGHT LOSS  
& WELLNESS CENTER

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MEDICALLY SUPERVISED WEIGHT LOSS

To whom it may concern:

Valentine Weight Loss and Wellness Center is requiring all patients to have the following lab work:

CBC –Complete Blood Count

CMP-Comprehensive Metabolic Panel

TSH-Thyroid Stimulating Hormone

Lipid Profile- Cholesterol and Lipids

The labs above are medically necessary and a requirement of the American Society of Bariatric Physicians. If you have had the lab work performed within the last 6-9 months that will be acceptable. You have the option of obtaining these labs with your Primary Care Physician or we can perform these labs in our office .The cost within our lab is \$60.00 (Please be advised We Do Not file Insurance). Thank you for your cooperation on this matter and we look forward to treating you for your weight loss and wellness needs.

Sincerely,

Gregory Valentine M.D