

\*PLEASE NOTE WE DO NOT  
ACCEPT CHECKS. ALL OTHER  
FORMS OF PAYMENT ACCEPTED.



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

**EKG\*\*\***

**\*\*\* necessary if you are over 49 or have a major medical issue like Hypertension, High Cholesterol, or Diabetes. Those with a family history of certain medical problems may be required to get an EKG**

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 9-12 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

## **PLEASE READ IF YOU ARE PROVIDING YOUR OWN LABS OR EKG**

IF YOU HAVE CONTACTED YOUR DOCTOR'S OFFICE AND ARE HAVING YOUR LABS FAXED OR MAILED TO US, PLEASE CALL YOUR DOCTOR OR OUR OFFICE TO VERIFY THAT THEY HAVE BEEN SENT. PLEASE GIVE YOUR DOCTOR'S OFFICE AT LEAST THREE BUSINESS DAYS. IN OUR EXPERIENCE 75% OF LABS AND EKG'S ARE NOT SENT TO OUR OFFICE. IF YOUR LAB WORK OR EKG IS NOT HERE AT THE TIME OF YOUR VISIT, BASED ON OUR MEDICAL GUIDELINES WE WILL NOT BE ABLE TO ISSUE PRESCRIPTION APPETITE SUPPRESSANTS.

\*PLEASE NOTE THAT YOU CAN STILL HAVE YOUR FIRST VISIT EXCLUDING PILLS. WE WILL WRITE A PRESCRIPTION OR YOU CAN PICK PILLS UP UPON RECEIPT OF YOUR LAB WORK OR EKG.

\* IF YOU HAVE TO CALL YOUR DOCTOR FROM OUR OFFICE IT MAY ADD SIGNIFICANT TIME TO YOUR VISIT

**\*\*\*\*WE HIGHLY RECOMMEND\*\*\*\***

**THAT YOU HAVE YOUR LABS OR EKG SENT DIRECTLY TO YOU.**



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**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

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

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

<b>Past Health History</b>	<b>Complete to the best of your knowledge</b>			
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		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: \_\_\_\_\_

<b>Major Surgeries</b>
------------------------

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

If yes, please explain:


<b>Medication Allergies</b>
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Medication Name	Reaction

<b>Prescribed Medications &amp; Over-the-Counter drugs, dietary supplements (including vitamins, inhalers, etc.)</b>
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Medication Name	Strength	Frequency

# VALENTINE WEIGHT LOSS & WELLNESS CENTER DIETARY SURVEY

\*PLEASE NOTE WE DO NOT  
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*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?**

- never been married
- single
- divorced
- widowed
- married

- separated
- remarried
- engaged
- deceased spouse
- life partner

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

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

- no offspring
- one child
- multiple children( how many) \_\_\_\_\_

- One step child
- multiple step children( how many): \_\_\_\_\_

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

d) **What are your sleep patterns**

- sleep walks
- have sleep apnea
- complains of insomnia

- unusual sleep patterns
- wakes up at night
- uses sleep aids
- no sleeping issues

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

- no stress related issues
- out of work
- adult family members in the home
- alcoholism in the family
- children in the home
- drugs in the home
- drug use in family
- financial difficulties

- illness in the family
- martial difficulty
- psychiatric illness in family
- recent death in family
- recent trauma
- stress at work
- recent changes in home
- other: \_\_\_\_\_

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

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

- elementary school
- high school diploma
- undergraduate degree

- graduate degree
- completed some college
- unknown

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

- no history of using cigarettes
- I smoke \_\_\_\_\_ pack(s) per day
- I have currently been smoking for \_\_\_\_\_ years

- I use to smoke for \_\_\_\_\_ years
- I stoped smoking cigarettes \_\_\_\_\_ years ago

h) **Do you drink caffeine beverages**

- I do not drink caffeine
- drink minimal amount of caffeine
- drink caffeine occasionally
- drink caffeine daily

- drink caffeine moderately
- drink caffeine heavily
- I drink \_\_\_\_\_ cups of caffeine per day

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

- never drink alcohol
- does not currently drink alcohol
- drink occasionally

- drink moderate amounts of alcohol
- drink heavy amounts of alcohol
- 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?**

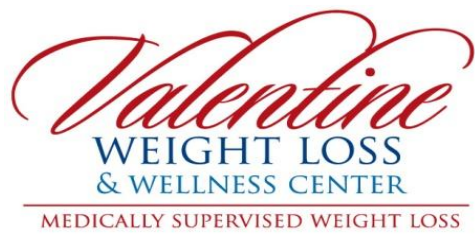
- Time: \_\_\_\_\_
- |   |  |
|---|--|
| <input type="checkbox"/> skip dinner            | <input type="checkbox"/> rice/potatoes   |
| <input type="checkbox"/> home cooked meal       | <input type="checkbox"/> vegetables      |
| <input type="checkbox"/> frozen meal            | <input type="checkbox"/> 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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## Prices as of 2/10/2011\*

<b>Basic 1st Visit (If you bring your own Labs and EKG)</b>	<b>\$ 119</b>	
<i>Comprehensive medical consultation</i>		
<i>Free computer based dietary consultation and plan (based on your lean body mass)</i>		<i>\$35 value included in initial visit</i>
<i>Exercise Plan</i>		
<i>Appetite Suppressants</i>		
<i>Basic Visit With Full Labs (CBC, TSH, CMP, Lipid Panel)</i>	<i>\$ 184</i>	<i>\$120 savings vs. hospital</i>
<i>Basic Visit With EKG (for Pt's over 50yrs old or w/ med. Conditions)</i>	<i>\$ 179</i>	
<i>Basic Visit With Full Labs and EKG</i>	<i>\$ 244</i>	

### ITEMIZED PRICING

Monthly Follow Up Exams	\$ 60	
Prescription Appetite Suppressants	\$29 - \$60	<i>We have over 6 types of diet pills</i>
Natural Appetite Suppressants	\$ 36	
Dietary Consultations & Meal Plan (free w/ first visit)	\$ 40	
Lab Panel (CBC,CMP, TSH,Lipid panel)	\$ 70	<i>\$150 savings vs. hospital</i>
Regular B12 injection	\$ 15	<i>energy</i>
Super/Methyl B12 injection (more bio-available - its stronger)	\$ 15	<i>energy</i>
MIC injection (lipotropic)	\$ 15	<i>fat flushing</i>
Lipo- Plex injections (combines all of our shots)	\$ 20	<i>Double B12, B5, B6, B2</i>
Blood Sugar Lowering Agents	\$ 33	
Omega 3's (high quality enteric coated)	\$ 26	
Meal Replacement Shake (Month Supply)	\$ 66	
Meal Replacement Bars	\$1.50- \$2.50	

*We have many more weight, blood sugar, and cholesterol lowering supplements. We will suggest additional supplements based on your specific health needs.*