WEIGHT MANAGEMENT

PATIENT PREPARATION FORM

Whether it's your personal medical history, available coverage options, or writing down specific, attainable, short- and long-term goals, this form can help you and your health care team plan for your weight management.

Name **Date of Visit**

Date of Birth **Height** **Weight** **BMI**

Please answer these questions as truthfully as possible so together we can develop a personalized weight-loss plan for you.

Do you ever feel like your eating patterns can get out of control? ○ YES ○ NO

Do you eat between meals? ○ YES ○ NO

Do you eat as a response to your emotions? ○ YES ○ NO

Do you have any dietary restrictions? ○ YES ○ NO

Do you currently take part in physical activity? ○ YES ○ NO

Have you been diagnosed with any of the following:

Type 2 diabetes? ○ YES ○ NO

High blood pressure? ○ YES ○ NO

High cholesterol? ○ YES ○ NO

What prescription medications, if any, do you currently take? _____

What kind of foods do you eat? _____

How many times a week do you take part in physical activity? ____ How long do your sessions of physical activity last? _____

What type of physical activity? _____

What are your weight/obesity-management goals?

Short-term goals: _____

Long-term goals: _____

How many serious weight-loss attempts have you made in the past 5 years? ○ 0 ○ 1 ○ 2 ○ 3 ○ 4+

Did you participate in any structured weight-loss programs in the past and, if so, which ones?

_____

Was there one program that seemed to work best for you?

_____

What are some barriers that have kept you from losing weight and maintaining weight loss in the past? *(eg, nutritional choices, no time for exercise, health issues)*

_____

Have you ever been on an anti-obesity or weight-loss medication in the past or are you currently on one? *(either over the counter or prescribed)* ○ YES ○ NO

If so, which one(s): _____

Current anti-obesity/weight-loss medications: _____

TAKING CONTROL OF YOUR

WEIGHT MANAGEMENT

Your insurance provider may include weight-management treatments as part of your plan. Contact your carrier or employer for more information about coverage.

Nutritionist/Dietitian

○ YES ○ NO Co-pay: Sessions:

Behavioral therapist

○ YES ○ NO Co-pay: Sessions:

Health Coach

○ YES ○ NO Provider visit for weight management:

Gym membership

Discount ○ YES ○ NO

Reimbursement ○ YES ○ NO

Ask if your place of employment offers a wellness program, which can include:

Smoking cessation program ○ YES ○ NO

Health screenings and wellness assessments ○ YES ○ NO

Stress management education ○ YES ○ NO

Weight-loss program ○ YES ○ NO

Insurance coverage

Does your insurance cover pharmacotherapy for weight loss? ○ YES ○ NO

Does your insurance cover weight-reduction surgeries? ○ YES ○ NO

Follow-up appointment

Date: Time:

Office contact information

Name:

Phone:

E-mail:

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