#

*Welcome to my practice. I’m honored to be your bariatric physician, and I’m committed to providing*

 *you with the best care I can. My hope is that we form a partnership to keep you as healthy as possible,*

*no matter what your current state of health. I will share my medical expertise with you, and I hope*

 *you’ll take responsibility for working toward the healthy lifestyle that is so important to your well*

 *being. Few of us, myself included, have a completely healthy lifestyle, but each day we can take*

*a step closer to a healthier life.*

It will give me great pleasure to work with you on your weight control goals, either through my own

 expertise, through reading I might give you, or by referring you to the nutritionist at American Weight Loss.

 I encourage you to keep in contact with your primary care doctor.

*We want everyone to be involved in their own health maintenance program. Everyone who joins our*

 *practice will start by having a physical exam followed by periodic check-ups to watch out for*

*problems* and modify your program. We will make you aware of the food and supplement programs

available to *achieve maximum success. Additional tests may be recommended and also medications*

 *to assist you will be discussed if you so desire.*

We look forward to working with you. Let’s work together to help you live the satisfying life that

 you deserve.

*Enclosed you will find a Patient Registration, Medical History and Screening Forms. Bring all*

*completed forms, driver licenses, bottles of all pills you take including over the counter medications,*

*copies of blood work, EKG (heart test, to your appointment* ***on \_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_ @\_\_\_\_\_\_\_\_\_\_\_\_\_\_location .*** *Your cost for your 1st initial office visit could be****\_\_\_\_\_\_\_\_\_*** *and any*

*additional medications or supplements****.***

***We ask everybody to be courteous to all patients/staff and******refrain from wearing any perfumes/cologne to your appointment.***

*Sincerely,*

*Erin Chamberlin- Snyder MD and staff*

*Locations:*

Noblesville: 9669 E. 146th St, Suite 148, 46060

Indianapolis-South: 5145 S. Meridian Street, Suite B, Indianapolis 46217

Anderson: 1537 S Scatterfield, Suite C (White River Complex), 46016

*765-644-5673\*\*1888-636-0333\*\*Fax 765-644-4997*

All Righs Reserved. No part of the form should be reproduced or transmitted in any form or by electronic,mechanical/photocoying,recording without permission from the copyright holder

Erin Chamberlin-Snyder MD

Patient Registration

# Date: \_\_\_/\_\_\_\_/\_\_\_\_ DL #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_ Exp\_\_\_\_/\_\_\_

# Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: Male----Female Age: \_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: S M Sep Div Wid

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ Height \_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip: \_\_\_\_\_\_\_\_\_\_ Race: (Optional research ONLY) cac /afr-am/ other

Home Phone(\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What Phone number may we leave a DETAILED message on?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Circle & Sign: Telephone Call or Text for confirming appointment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (patient signature)

Patient’s Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip: \_\_\_\_\_\_\_\_

## Spouse, Partner, or Guardian’s Information:

# Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Family Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Insurance Co:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Give Card to front Desk/Driver License

# Insurance Cardholder Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employment of Cardholder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Date of Birth of Cardholder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Cardholder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Emergency Numbers:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Nearest relative not living with you….Mother..Sister..Aunt..Neighbor..Friend)

# How did you hear about our practice: Newspaper---Phone Book---Friend---Physician Referral

Name of Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Office Policy’s

1. Payments for Office visits, Lab, EKG, Elg, Supplements, and nutrition counseling are due at the time of services, unless prior arrangements have been made. If your insurance has not paid on your account within thirty days of being billed your will be responsible for contacting your insurance company and for paying the remaining balance owed.
2. All new patients CBC,TSH, Lipid Panel, Complete Metabolic Profile, UA and EKG must get blood tests done at Dr Chamberlin-Snyder’s office. According to American Society of Obesity Physicians Practice Guidelines, all test and paper work must be completed and presented before the Physician can place the patient on a VLCD or medication.
3. We accept Cash, Visa, Master Card, and Debit Cards.
4. To avoid a $25.00 failure charge, no show , you must notify our office within 1 business day to cancel your appointment.

All Righs Reserved. No part of the form should be reproduced or transmitted in any form or by electronic,mechanical/photocoying,recording without permission from the copyright holder

1. **Please ask the doctor for all your needed refills during your office visits. Prescriptions will not be called into the pharmacy between office visits.** To prevent possible medication errors the Doctor does not refill medications by fax or pharmacy phone calls. If you receive a medication from your primary doctor call their office for refills.
2. I understand that Medicare/Medicaid will not pay for any weight loss services rendered by Erin Chamberlin-Snyder MD even if I bill Medicare or Medicaid myself. Medicare may cover dietary and behavioral counseling if your Body Mass index is >/= 30, & if the services are provided by your primary care doctor.\_\_\_\_\_\_\_initials
3. I authorize Dr Erin’s Weight Loss/ Erin Chamberlin-Snyder MD to furnish information to insurance carriers concerning my treatment and I hereby assign to the physician all payments. I, the undersigned, am fully aware weight loss counseling may be a non-covered service; therefore, the balance is my responsibility. In the event of default of payments when due, Erin Chamberlin-Snyder MD, has the right, but not the obligation, to declare the entire amount to be immediately due. Dr. Erin’s Weight Loss/Erin Chamberlin-Snyder MD has the right to declare an additional $10.00 to the unpaid balance every 30 days. In the event that the balance is not paid within 90 days your account will be referred to collections. The undersigned agrees to pay all costs of collections, including but not limited to collection fees, court cost, and reasonable attorney’s fees.
4. If Patient is requesting a copy of MD notes, there is a $ .15 charge per page or $ 15.00 for chart.
5. There is a $ 50.00 charge for letters written to summarize physician supervised treatment for purposes of bariatric surgical referral or authorization. There is a $ 15.00 charge for work/wellness PE forms.

HIPPA:

I consent to Dr. Erin’s Weight Loss and their physicians to use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice’s general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and their general operation activities, I understand that the Practice’s diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice. I understand I have the right to review and request a copy of the Practice’s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice’s duties regarding the types of uses and disclosures of my Protected Health Information. I give Erin Chamberlin-Snyder MD permission to call/test my home, work, cell or mail any information regarding my appointment or reminders to me or give any information to my immediate family.\_\_\_\_\_\_\_initials

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent. I further acknowledge that I have received, reviewed, understood and agreed to the Notice of Privacy Practices of Erin Chamberlin-Snyder MD, which described the Practice’s policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signature (Parent or guardian must sign for patients under 18 years old) Witness

All Righs Reserved. No part of the form should be reproduced or transmitted in any form or by electronic,mechanical/photocoying,recording without permission from the copyright holder

Medical History Form

PLEASE FILL IN ALL BLANKS/CIRCLE OR PRINT “NONE” IF APPLICABLE**.**

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

Name: Age: Date of Birth\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_Sex: M F Height\_\_\_\_\_\_\_\_

Primary Care Physician: Dr. Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it OK to send information to your physician YES or NO

**Present Status:**

1. Are you in good health at the present time to the best of your knowledge? Yes No

2.Are you taking any medications/supplements(over the counter pills) at the present time? Yes No

**Med. Name** **MG** **Dosage** **Time Taken** **Date Started Med.** **For what Problems?**

 / / / / /

 / / / / /

 / / / / /

\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.Any allergies or sensitive (side effects) to any medications? Yes No

 Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 / \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever been told you have High Blood Sugars (Diabetes)? When:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No
2. Have you ever had heart problems, Heart attack or Chest Pain? Yes No If yes when\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Have you ever had a stress test on your heart? Yes No If yes when\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Have you ever had Migraines/Headaches? Yes No Medications for Migraines: \_\_\_\_\_\_\_\_

8. History of Constipation (difficulty in bowel movements)? Yes No How often do you have bowel movements\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. When was your last Eye Exam?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you ever had glaucoma? Yes No

10. Gynecologic History:

 Deliveries: Number: Dates: Any High Blood Sugars? Yes No

 What are you using to prevent pregnancy?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 11. Other Medical Problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12.Any Surgeries/Hospitalization Yes No

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

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

13. History of sleep problems? Yes No Have you had a sleep study? Yes No What was the result?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Your Past Medical History**: (**check all that apply) write down date of illness

\_\_\_\_\_\_\_\_ High Blood Sugars \_\_\_\_\_\_ Jaundice \_\_\_\_\_\_\_Chest Pain \_\_\_\_\_\_\_ Arthritis

 Kidney Disease \_\_\_\_\_\_ Scarlet/Rheumatic Fever \_\_\_\_\_\_\_ Liver Disease \_\_\_\_\_\_\_ Lung Disease

\_\_\_\_\_\_\_\_ Chicken Pox \_\_\_\_\_\_ Bleeding Disorder \_\_\_\_\_\_\_\_ Gout \_\_\_\_\_\_\_ Osteoporosis

\_\_\_\_\_\_\_\_ Ulcers \_\_\_\_\_\_ Thyroid Disease Anemia \_\_\_\_\_\_ Heart Valve Disorder \_\_\_\_\_\_\_\_ Heart Disease \_\_\_\_\_\_ Tuberculosis \_\_\_\_\_\_\_\_ Gallbladder Disorder \_\_\_\_\_\_\_ Blood Transfusion

\_\_\_\_\_\_\_\_ Drug/Alcohol \_\_\_\_\_\_ Eating Disorder(anorexia) \_\_\_\_\_\_\_\_High Chol. \_\_\_\_\_\_\_ Depression

\_\_\_\_\_\_\_\_ Pneumonia/Asthma \_\_\_\_\_\_ Marijuana Treatment \_\_\_\_\_\_\_\_ Cancer

\_\_\_\_\_ Chronic pain What hurts\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Circle level 1 2 3 4 5 6 7 8 9 severe

Family History: At what age did any of your family members have the following problems:

 Alive Death Stroke Heart Thyroid Diabetes Glaucoma Obesity B/P High Chol. Other No Problems

 Age of Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Age of Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Age of Brothers \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Age of Sisters: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Reviewed by Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(initials)

All Righs Reserved. No part of the form should be reproduced or transmitted in any form or by electronic,mechanical/photocoying,recording without permission from the copyright holder

PLEASE FILL IN ALL BLANKS/CIRCLE OR PRINT “NONE” IF APPLICABLE**.**

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_Today Date:\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Nutrition Evaluation**:**

1. Present Size: Desired Size\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. In what time frame would you like to be at your desired size? Size at 20 years of age: \_ Size one year ago:\_\_\_\_\_\_\_\_\_

3. What is the main reason for your decision to lose weight?

4. When did you begin gaining excess weight? (Give reasons, if known):

5. Previous diets you have followed: When/How much did weight did you lose? What Medications used Any Side Effects?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. What medications used in past?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Who lives in your Home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ages \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ages \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. How often do you eat out? Where?\_\_\_ When\_\_\_\_\_\_\_\_\_\_\_\_\_

9 Do you use a shopping list? Yes No

10. Food allergies:

11. Food dislikes:

12. Food you crave: When?

13. Do you drink coffee or tea? Yes No How much daily?

14. Do you drink soft drinks? Yes No How much daily? \_\_\_\_diet or regular

15. Do you drink alcohol? Yes No What Kind ?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How many a week?\_\_\_\_\_\_\_\_\_\_

16. Do you awaken hungry during the night? Yes No

 What do you do?

17. What are your worst food habits?

18. Do you think you are currently undergoing a stressful situation or an emotional upset, that would effect your eating?

 \_\_ \_\_\_\_

19. Are you being physically abused Yes No Sexually abused Yes No Emotionally abused Yes No

20. In the past have you been Physically abused Yes No Sexually abused Yes No Emotionally abused Yes No

21. 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 used to smoke \_\_\_\_\_\_ packs per day\_\_\_\_\_\_\_for years\_\_\_\_\_\_\_\_\_\_but Quit\_\_\_\_\_\_\_\_\_year

 You smoke \_\_\_\_\_Cigarettes per day For \_\_\_\_\_\_\_\_\_ years?

 22. Have you ever taken Wellbutrin or Zyban? Yes No Why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Any side effects\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

23. Describe your usual energy level:

 24. 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.

 25. Typical Breakfast Typical Lunch Typical Dinner

 Time eaten: Time eaten: Time eaten:

 Where: Where: Where:

 With whom: ­ With whom: With whom:

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.

2. Reviewed by Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(initials)

All Righs Reserved. No part of the form should be reproduced or transmitted in any form or by electronic,mechanical/photocoying,recording without permission from the copyright holder

##### Weight Loss Program Consent Form

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize Erin Chamberlin-Snyder MD and whomever is 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 duration’s 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:**  / / **Time:**

**Witness:**  **Patient:**

 (Or person with authority to consent for patient)

All Righs Reserved. No part of the form should be reproduced or transmitted in any form or by electronic,mechanical/photocoying,recording without permission from the copyright holder

12 Reasons

### “Why I want to Reach My Goal Weight”

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_Date\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_

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.”** Try to make them specific, measurable, and time related. (IE I want to be able to walk 5 blocks without being short of breath by June 2015)

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anderson/Noblesville/Indianapolis-South

765-644-5673/1-888-636-0333

All Righs Reserved. No part of the form should be reproduced or transmitted in any form or by electronic,mechanical/photocoying,recording without permission from the copyright holder