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.

Please answer these questions as truthfully as possible so together we can develop a personalized veight-loss plan for you. Do you ever feel like your eating patterns can get out of control?	Name		Date of Visit			
Do you ever feel like your eating patterns can get out of control? Do you ever feel like your eating patterns can get out of control? Do you ever feel like your eating patterns can get out of control? Do you eat as a response to your emotions? VES NO Do you have any dietary restrictions? VES NO Do you currently take part in physical activity? YES NO Have you been diagnosed with any of the following: Type 2 diabetes? VES NO High blood pressure? VES NO High cholesterol? VES 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? What are your weight/obesity-management goals? What are your weight/obesity-management goals? How many serious weight-loss attempts have you O O 1 O 2 O 3 O 4+ made in the past 5 years? Did you participate in any structured weight-loss programs in the past and, if so, which ones? 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	Date of Birth	Height	Weight		ВМІ	
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? How many serious weight-loss attempts have you 0 1 2 3 4+ made in the past 5 years? 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			together	we can d	evelop a personalized	
Do you eat as a response to your emotions? 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 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 are your weight/obesity-management goals? How many serious weight-loss attempts have you 0 1 2 3 4+ How many serious weight-loss attempts have you 0 1 2 3 4+ How past 5 years? 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	Do you ever feel like yo	our eating patterns can get out of	control?	O YES	O NO	
Do you have any dietary restrictions? 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? How many serious weight-loss attempts have you 0 1 2 3 4+ Node many serious weight-loss attempts have you 0 1 2 3 4+ Node 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		Do you eat between	n meals?	O YES	O NO	
Do you currently take part in physical activity?	D	o you eat as a response to your er	notions?	O YES	O 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? What type of physical activity? What are your weight/obesity-management goals? How many serious weight-loss attempts have you 0 1 2 3 4+ made in the past 5 years? Did you participate in any structured weight-loss programs in the past and, if so, which ones? 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				O YES	O NO	
Type 2 diabetes?	Do y	ou currently take part in physical	activity?	O YES	O NO	
High blood pressure?	Have you	u been diagnosed with any of the f	following:			
High cholesterol? YES NO What prescription medications, if any, do you currently take? What kind of foods do you eat? How long do your sessions of physical activity last? What type of physical activity? What are your weight/obesity-management goals? What are your weight/obesity-management goals? How many serious weight-loss attempts have you 0 1 2 3 4+ made in the past 5 years? 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		Type 2 d	iabetes?	O YES	O NO	
What kind of foods do you eat?		High blood p	ressure?	O YES	O NO	
What kind of foods do you eat? How long do your sessions of physical activity last? What type of physical activity? What are your weight/obesity-management goals? What are your weight/loss attempts have you 0 1 2 3 4+ Inade in the past 5 years? Oid you participate in any structured weight-loss programs in the past and, if so, which ones? 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 Foo, which one(s):		High cho	lesterol?	O YES	O NO	
Now 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? How long do your sessions of physical activity last? What are your weight/obesity-management goals? Short-term goals: ong-term goals: How many serious weight-loss attempts have you 0 1 2 3 4+ made in the past 5 years? 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)	What prescription medication	ons, if any, do you currently take?				
What are your weight/obesity-management goals? Short-term goals: Jong-term goals:	What kind of foods do you e	at?				
What are your weight/obesity-management goals? Short-term goals: Joing your many serious weight-loss attempts have you 0 1 2 3 4+ The past 5 years? Joing 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):	How many times a week do y	ou take part in physical activity? How	long do your	sessions o	of physical activity last?	
chort-term goals: cong-term goals: chow many serious weight-loss attempts have you 0 0 1 0 2 3 0 4+ chow many serious weight-loss attempts have you 0 0 1 0 2 0 3 0 4+ chow many serious weight-loss programs in the past and, if so, which ones? Old 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)	What type of physical activity	y?				
chort-term goals: cong-term goals: chow many serious weight-loss attempts have you 0 0 1 0 2 3 0 4+ chow many serious weight-loss attempts have you 0 0 1 0 2 0 3 0 4+ chow many serious weight-loss programs in the past and, if so, which ones? Old 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)	What are vour weight/	obesity-management goals?				
How many serious weight-loss attempts have you 0 0 1 0 2 0 3 0 4+ made in the past 5 years? 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)						
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 f so, which one(s):	Long-term goals:					
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) OYES NO f so, which one(s):			O 1 (2 0	3	
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) To so, which one(s):	Did you participate in a	iny structured weight-loss prograi	ms in the p	ast and,	if so, which ones?	
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) The so, which one(s):	Was there one progran	n that seemed to work best for you	u?			
rurrently on one? (either over the counter or prescribed) OYES ONO f so, which one(s):			eight and	maintai	ning weight loss in the	
f so, which one(s):					t or are you	
		,				

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.

O YES O NO Co-pay: Sessions:		
Behavioral therapist		
O YES O NO Co-pay: Sessions:		
Health Coach		
○ YES ○ NO Provider visit for weight management:		
Gym membership		
Discount OYES ONO		
Reimbursement OYES ONO		
Ask if your place of employment offers a wellness program, which can include:		
Smoking cessation program	O YES	O NO
Health screenings and wellness assessments	O YES	O NO
Stress management education	O YES	O NO
Weight-loss program	O YES	O NO
Insurance coverage		
Does your insurance cover pharmacotherapy for weight loss?	O YES	O NO
Does your insurance cover weight-reduction surgeries?	O YES	O NO
Follow-up appointment		
Date: Time:		
Office contact information		
Name:		
Phone:		
E-mail:		

