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

Valentine
WEIGHT LOSS
& WELLNESS CENTER
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

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 SUPRESSANTS.

*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:_____

Past Health History

Complete to the best of your knowledge

	Family	Personal
ADD		
ADHD		
Alcohol Abuse		
Anemia		
Arthritis		
Asthma		
Bleeding Disorder		
Bloody Stool		
Bronchitis		
Cancer		
Celiac Disease		
Chest Pain		
COPD		
Constipation		
Convulsions		
Depression		
Diabetes		
Diarrhea		

	Family	Personal
Dizzy Spells		
Drug Abuse		
Eating Disorder		
Epilepsy		
Emphysema		
Fainting Spells		
Fatigue		
Fibromyalgia		
Frequent Urination		
Gallbladder Disorder		
Glaucoma		
Headaches		
Heart Disease		
High Cholesterol		
Hypertension		
Insomnia		
Irregular Pulse		
Kidney Disease		

	Family	Personal
Liver Disease		
Lung Disease		
Migraines		
Mood Swings		
Nervousness		
Obesity		
Palpitations		
Psychiatric Illness		
Rashes		
Seizures		
Shortness of Breath		
Stroke		
Thyroid Disease		
Prior Diet Pill Use		
(LIST ANY OTHER HEALTH ISSUES)		
_____		
_____		
_____		

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

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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?**

- ☐ 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?

- ☐ Self Esteem
- ☐ Role Model for Family
- ☐ Relationship
- ☐ Other
- ☐ Overall Health
- ☐ Appearance
- ☐ Medical Problems
- ☐ Feel Better

k) When did you begin gaining weight?

approximate date:_____

- ☐ since childhood
- ☐ after sickness
- ☐ after children
- ☐ after stressful event

other (explain):_____

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

- ☐ lack of will power
- ☐ peer/family pressure
- ☐ lack of motivation
- ☐ medical problems
- ☐ lack of knowledge of healthy foods
- ☐ lack of exercise

other (explain):_____

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

- ☐ tried on your own
- ☐ low carb diet
- ☐ the zone
- ☐ south beach
- ☐ blood type diet
- ☐ weight watchers
- ☐ Mediterranean diet
- ☐ nutri-system

other (explain):_____

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

o) Have you excercised 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?

- ☐ I do not exercise
- ☐ jog
- ☐ walking
- ☐ treadmill
- ☐ elliptical trainer
- ☐ weights
- ☐ personal trainer
- ☐ bike
- ☐ swim
- ☐ aerobics
- ☐ dance classes

other (explain):_____

r) What is the length time spent exercising per session

- ☐ 15 min
- ☐ 20 min
- ☐ 30 min
- ☐ 45 min
- ☐ 60 min
- ☐ over 60 min

t) What foods do you crave?

- ☐ vegetables
- ☐ carbs
- ☐ candy/sweets
- ☐ breads
- ☐ pastries, cakes, donuts, cookies
- ☐ fast food
- ☐ fried food
- ☐ chicken
- ☐ white rice
- ☐ tortillas
- ☐ beef
- ☐ pork
- ☐ fish
- ☐ high fiber foods
- ☐ soda (non diet)
- ☐ diet soda
- ☐ juice/punch
- ☐ chips
- ☐ ice cream
- ☐ 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*_____

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

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

- ☐ Not eating healthy
- ☐ skipping meals
- ☐ taste of healthy food
- ☐ a need to finish everything on plate
- ☐ peer/family pressure
- ☐ social activities/parties
- ☐ alcohol/beer/wine
- ☐ soda /juice /punch
- ☐ late night snacks
- ☐ financial issues

other (explain):_____

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

Time:_____

- ☐ skip breakfast
- ☐ cereal
- ☐ eggs
- ☐ breakfast meat
- ☐ coffee
- ☐ breads
- ☐ pastries/cakes/donuts
- ☐ fast food
- ☐ restaurant food
- ☐ frozen meal

other (explain):_____

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

Time:_____

- ☐ skip lunch
- ☐ sandwich
- ☐ soup
- ☐ salad
- ☐ frozen meal
- ☐ fruit
- ☐ yogurt
- ☐ energy drink
- ☐ protein drink
- ☐ protein bar
- ☐ fast food
- ☐ restaurant food

other (explain):_____

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

Time:_____

- ☐ skip dinner
- ☐ home cooked meal
- ☐ frozen meal
- ☐ salad
- ☐ sandwich
- ☐ meats
- ☐ rice/potatoes
- ☐ vegetables
- ☐ fast food
- ☐ restaurant food
- ☐ protein shake
- ☐ protein bar

other (explain):_____

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

_____

_____

_____