RAINIER MEDICAL Enrollment Application

How did you hear about us: Returning Patient, Internet Search, Word of mouth, Physician, TV, newspaper, walk-by, Other

If word of mouth, whom may we thank for referring you? _____

NOTE: Please complete this form prior to your initial consultation so Dr. Sutherland can be prepared for your time. Please do your best to answer every question if you are comfortable, or you can wait and note you would like to discuss in person if you prefer. Please print, type or write clearly.

Name (Last-First-Initial)		
Address (Street-City-State-Zip)		Cell Phone No.
Occupation (optional):	Work schedule (optional):	Secondary Phone No.
Birth date (Month-Day-Year)	Circle Household Status (circle all that apply, optional) Single Joint Children Extended Family Pets	Gender assigned at birth (optional) □ Male □ Female □ Other
Email: Can we email/text about appointments? □ Yes □ No	May we add you to our mailing list which may include informational as well as promotional items: Yes No	Preferred Pronouns: □ he/him □ she/her □ they/them □ other

WEIGHT HISTORY

Current weight (lbs)	Estimate your weight at the following ages and any sentinel event such as pregnancy, job change, stoping smoking, or a new medication:
Current height (feet, inches)	18: _____lbs. Event: _____ 35: _____lbs. Event: _____
What is the weight where you feel comfortable and that is "maintainable?"	25: _____lbs. Event: _____ 45: _____lbs. Event: _____
When were you last at this weight?	30: _____lbs. Event: _____ 55: _____lbs. Event: _____

How much weight do you expect to lose during this program? _____ lbs.
Are there any medications, health issues, or life events that you feel have had a dramatic and direct effect on your weight? yes no
If so, please describe: _____

Which weight loss methods have you tried in the past? Please be as specific as possible (eg. NutriSystem, Jenny Craig, HCG,Meal Replacements, Medications, Spa, Hypnosis, Weight Watchers, Psychotherapy, Etc.)

Weight loss method	How long was loss maintained?	Why did you stop treatment?	Problems during treatment	Which weight loss method do you consider your most successful?
Sample: Stillman Diet	*2 months*	*Desired other foods*	*Dizziness*	
				What accounted for that success?

Name: DOB:

MEDICAL HISTORY

Who is you Primary Care Provider? (Note: Dr. Sutherland's primary care practice is a concierge style model.)

Name City:

When was your most recent complete physical exam? Month: Year:

Current and Past Medical Issues

Medications (Name, strength, dose, frequency):

Past Surgical History:

Method of Contraception: (abstinence, menopause, infertility, condoms, pills, IUD, implant, surgical in self, surgical in partner):

Medication Allergies:

Food Allergies or Restrictions:

Family Medical Problems (including obesity):

Do you use tobacco? ▫ Yes ▫ No ▫ Quit _____ years ago

Please check any health condition you have had:

- ▫ Heart attack within last 3 months
- ▫ Type 1 Diabetes
- ▫ Liver disease requiring protein restriction
- ▫ Pregnant or planning to become pregnant within 6 months
- ▫ Kidney disease requiring protein restriction
- ▫ Recent treatment for cancer (please describe)
- ▫ Recent uric acid kidney stone or untreated hyperuricemia (gout)
- ▫ Peptic ulcer disease that is not resolved or under good medical control
- ▫ Recent onset of inflammatory bowel disease
- ▫ Seizure
- ▫ Heart issue
- ▫ Use of opiates (pain medication or heroin)
- ▫ Obstructive Sleep apnea (On treatment? yes no)

Date of most recent menstrual period _____

Number of pregnancies _____

Weight gain with pregnancies _____ lbs

Do you have any of the following symptoms AT THE PRESENT OR RECENT TIME to a degree that is more than you would expect that are not currently controlled? (Circle al that apply.)

Constitutional symptoms: fever, unintentional weight loss, extreme fatigue

Cardiovascular: chest pain with exertion, palpitations, light-headededness, passing out

Respiratory: wheezing, shortness of breath, COPD, snoring, irregular snoring

Genitourinary: irregular menses, vaginal bleeding after menopause, urinary incontinence

Neurological: headache, migraine, excessive daytime fatigue, falling asleep

Musculoskeletal: knee pain, shoulder pain, hip pain, back pain, gout

Psychiatric: depression, anxiety, suicidal thoughts, panic attacks, OCD, binge eating

Endocrine: infertility, reduced libido, erectile dysfunction, anorgasmia, irregular menses, PCOS, enlarged breast tissue for men, hair loss

Skin: varicose veins, sun damage, skin tags

PSYCHOSOCIAL HISTORY

Are you at present undergoing any major lifestyle changes (eg, marriage, divorce, job change, death of someone important to you)? If so, describe:

What other commitments do you that might interfere with your fully participating in the program?

What benefits do you hope to gain from being in this program other than losing weight?

Who do you feel will be supportive of your weight loss and changes in lifestyle? (circle and name your choices)
Spouse Children Roommate(s) Parent(s) Friend(s) Co-worker(s) Other

Who do you feel may **not** be supportive of your weight loss and changes in lifestyle? (circle and name your choices)
Spouse Children Roommate(s) Parent(s) Friend(s) Co-worker(s) Other

List five reasons you think it is important for you to lose weight. Please number the reasons, with "1" being the most important.

Why did you choose this particular program?

Are you currently or have you in the past been in any kind of psychotherapy? □ YES □ NO
If yes, please specify the diagnosis or symptoms or cause:
Do you currently have any mood symptoms such as depression or anxiety that are not controlled? □ YES □ NO

Have you been in any kind of psychotherapy in the past? □ Yes □ No
If yes, please specify:

Have you ever been hospitalized for psychiatric reasons? □ YES □ NO

Have you ever had suicidal thoughts? □ Yes □ No	Have you ever been severely depressed? □ Yes □ No □ Possibly	Have you ever experienced dramatic mood changes during dieting (especially anxiety or depression)? □ Yes □ No □ Possibly

Have you ever eaten a large amount of food rapidly and felt this eating incident was excessive and out of control (aside from holiday feasts)?
□ Yes □ No

If yes, how often did you do this during the past year? (check one)

□ Less than once a month
□ About once a week
□ About once a month
□ About three times a week
□ A few times a month
□ Daily

Have you ever purged (used self-induced vomiting, laxatives, or diuretics)? □ Yes □ No

Do you have anorexia nervosa or body dysmorphia? □ Yes □ No □ Not sure

Name: DOB:

LIFESTYLE AND EATING HABITS

Do you drink alcohol? □ Yes □ No

If yes, how much?
- □ 1 drink a month
- □ 1 drink a week
- □ More than 1 drink a week
- □ 1 drink a day
- □ More than 1 drink a day

How often do you exercise?
- □ Rarely
- □ Occasionally
- □ 1-2 times a week
- □ 3-4 times a week
- □ 5 or more times a week

Has any doctor or other health care professional ever told you not to exercise? □ Yes □ No

Do you know of any reason why you should not exercise? □ Yes □ No

What is your favorite type of exercise: _____ Have you ever done weight lifting?: _____

Do you have any restrictions on exercise, such as a joint issue? _____

If you answered yes to either question, please explain:

_____

_____

_____

How many meals do you typically eat out per week? _____

Are the majority of these meals with family or friends?
□ Yes □ No

Are they usually fast food (eg, McDonald's)? □ Yes □ No

Usually in cafeteria/restaurant? □ Yes □ No

Of the following, check all the items that you feel help explain or describe your eating habits:

- □ sugar addiction
- □ binge eating
- □ skipping meals
- □ time constraints- eating convenience foods
- □ Uncontrollable binges, especially when alone
- □ history of emotional, physical, or sexual abuse
- □ emotional eating
- □ relationship with significant other or family member
- □ soda or other sweetened beverages such as coffees
- □ Other (explain) _____

Please list any food allergies:

Are you always hungry, never hungry, or hungry to what you would consider an average degree? _____

Do you require "seconds" or large portions of food in order to feel satiated/full? _____

How often do you have intrusive thoughts about what you will be eating next, when your next meal is, or of food that you know is in the house?

_____

Do you have string cravings for certain foods that are difficult to overcome on a regular basis? _____

How many times have you "weight cycled" in your life, meaning lost weight on a plan and then regained it? _____

I certify that the information on this form is true and correct to the best of my knowledge.

_____ _____

Signature Date