CONFIDENTIAL Enrollment Application Rainer Medical Weight Loss & Wellness

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

If word of mouth, whom may we thank for referring you with a gift card? _____

NOTE: This form must be completed before you can be enrolled in a treatment plan. Please answer every question. Please print, type or write clearly.

Name (Last-First-Initial)			
Address (Street-City-State-Zip)		Cell Phone No.	
Occupation	Name of Employer	Secondary Phone No.	
Birth date (Month-Day-Year)	Circle Household Status (circle all that apply) Single Joint Children Extended Family Pets	SEX Male Female Other	
Email:	May we add you to our email list which may include informational as well as promotional items: Yes No	Would you like a free consultation with our aesthetician? Yes No	

WEIGHT HISTORY

Patient weight (lbs)	Estimate your weight at the following ages and any sentinel event such as pregnancy, job change, stoping smoking, or a new medication:
Present height (feet, inches)	18: _____lbs. Event: _____ 35: _____lbs. Event: _____
What is your goal weight?	25: _____lbs. Event: _____ 45: _____lbs. Event: _____
When were you last at your goal 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:

MEDICAL HISTORY

Who is you Primary Care Provider?

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:

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 or history of seizure

□ Heart issue

□ Use of opiates (pain medication or heroin)

□ Obstructive Sleep apnea (On treatment? yes no)

Date of last 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.)

General: fever, unintentional weight loss, extreme fatigue

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

Name:

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

Genitourinary: irregular menses, vaginal bleeding after menopause, urinary incontinence, pain with intercourse

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

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 life changes (eg, marriage, divorce, job change, death of someone important to you)? If so, describe:

What other commitments do you have that will compete for your time and attention?

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 make a health change. 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. Have you ever been hospitalized for psychiatric reasons? □ YES □ NO
If yes, please specify:

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

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

List any other information you wold like the medical team to have?

Name:

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 strong 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

CLIENT COMMITTMENT

Realizing that losing weight will require a great deal of time and effort on my part, I wish to participate in the Rainier Medical Weight Loss and Wellness Program, a medically monitored program for weight loss and weight control. I must meet medical and psychological screening criteria established by the Rainier Medical Team of weight loss management professionals before entering the program. If medical complications unrelated to weight loss arise during the program I will be referred back to my primary care provider.

My goal is to lose weight and to keep it off and I have been informed that weight regain will occur if specific and consistent measures are not taken to prevent it. I agree to participate in and complete all phases of the program—Active Weight Loss, Transition and Maintenance.

I will attend recommended follow up visits at all phase of the program and will notify the staff in advance when I am unable to attend. I realize that if I miss more than two sessions without prior arrangements, I can be discharged from the program. I also realize that I have the option of leaving the program at any time but I will be responsible for adhering to the practice's No Show/Late Cancellation policy. I also understand that once I leave, there may be a waiting period before I can re-enter and may not be permitted to participate in the full medical protocol but may be permitted to follow a modified protocol which is expected to result in slower weight loss.

I understand that in the interest of my health, I must maintain my weight loss once I reach my goal. Therefore, I am making the commitment to understand and practice the lifestyle changes presented in this program. If I find weight regain is occurring, I will contact the office of Rainier Medical Weight Loss & Wellness for a follow up appointment.

I agree to adhere to the Rainier Medical Weight Loss and Wellness Program by being actively involved in the weekly follow up visits. I also agree to purchase and consume the amount of the New Direction Nutritional Products prescribed to me, acknowledging that the safety and efficacy in the both the short term and long term are affected by my adherence to protocol. I understand that commercially available products are not an acceptable replacement. I understand that the products are my sole source of nutrition unless I am on a modified plan which includes one meal a day of table food. Once I have purchased the medical food, it is not returnable. I realize that if I am not complying with the program, I can be discharged.

I understand that the following are expectations of participants in the Rainier Medical Program for safety and efficacy, acknowledging not all risk can be eliminated and results can vary:

- Complete Enrollment Application, initial blood work, and New Start Visit.
- Pay non refundable enrollment fee.
- Attend coaching visits weekly during the Active Weight Loss phase, every 2 weeks during Transition Phase, and monthly for 3 months on Maintenance Phase. Obtain a weight check monthly on maintenance phase to remain an active member. Should I be absent for 60-180 days, a re-activation fee would apply should I wish to restart the active weight loss phase. Should I be absent for more than 180 days, the full enrollment fee applies should I wish to restart the active weight loss phase.
- Utilize the medical meal replacement products offered at RMWLW and not a commercially available product. The quality, safety, and efficacy can not be known of other products.
- Monitor my blood pressure at home if I have high blood pressure and my blood sugar if I have diabetes and alert the staff of any abnormalities.
- Communicate immediately any concerns I have with my program, my care, how I am feeling or how my body is responding.
- Obtain monthly blood tests at a Laboratories Northwest Laboratory within the week prior to my provider visit. If I choose to use a different lab, I will hand carry the lab order slip with me to get them drawn and make a follow up appointment with a provider to review the results.
- Schedule my provider visits so any program related prescription renewals are obtained during an office visit for optimal care. Follow up visits are typically conducted by a Physician Assistant - Certified.
- Sign up for MyChart and read any incoming message from the office unless there is some impediment to doing so, in which case I will inform the staff and call the office if I am unable to open a message.

- Obtain monthly Body Composition Analysis with an out of pocket cost of $45, having been advised this is important for assessment of the appropriateness of my plan.

I have read all the above statements and understand their meaning. It is my wish to participate in the Rainier Medical Program under the conditions described. I understand that if the medical recommendations are not fulfilled for any reason, my program may need to be modified or stopped.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____