HENRY FORD WEIGHT MANAGEMENT PROGRAM

Your initials_______

In order for us to process your enrollment form quickly and accurately, please print legibly and be sure to complete the entire form prior to the orientation meeting. If you are unsure of what to do please ask for assistance from a staff member at the orientation.

(circle one)
Mr. Ms. Mrs. First Name: ________________________ MI: ____ Last Name: _________________________

(circle one)
Male | Female DOB: ____/____/__________ E-Mail Address: _____________________________________

Address (include apartment or unit #):____

City: ____ State (Province): _________________________

Zip (Postal Code): _________________ Country: ____

Home Phone (include area code): ___________________________ Other Phone: _________________________

Primary Insurance: ____________________________ Secondary Insurance: ____________________________

Primary Physician: _________________________________ Physician Phone: ___________________________

Location where physician is seen:____

In order to have access to the web site and program support features you must select a unique username and password, as well as a reminder question and answer in case you lose your password.

*Your **Username** can contain alpha-numeric characters only (no special characters) and your **Password** should not be something easily guessed (but something easily remembered).*

Username: _________________________________ Password: ___________________________

Choose one of the following **Reminder Questions** by placing a checkmark in the appropriate box:

- What is your mother's maiden name?
- What was the name of your first pet?
- Whom do you most admire?
- What elementary school did you attend?

Record your answer here: ____

Marital Status (circle one): single | married | widowed | divorced Number of Children: _________

Number of people in your household: ________ Occupation: _________________________________

Number of working days per week: __________ Average number of hours per work day: __________

How physically active are you at work? (circle one): Not Very Active | Somewhat Active | Very Active

How physically active are you in your leisure time? (circle one): Not Very Active | Somewhat Active | Very Active

How many days per week do you participate in planned exercise like walking, biking or swimming? _________

If you do participate in planned exercise, how many minutes might you spend each time? __________

How many days per week might you participate in sports activities like bowling or golf? __________

HENRY FORD WEIGHT MANAGEMENT PROGRAM

Your initials_______

Do you experience physical discomforts that limit your ability to move or be active? Yes No

If yes, please describe: ____

On a scale of 1 to 10 rate your enjoyment of activities like walking, biking, swimming, aerobics, etc.

(I don't like at all) (I like very much)

Please circle your answer: 1 2 3 4 5 6 7 8 9 10

What are your two biggest barriers to performing regular exercise? (for example, lack of time or motivation)

1. _____________________________________ 2. _____________________________________

What was your weight at age 18? ________ Highest adult weight? ________ Lowest adult weight? ________

If you could weigh whatever you wanted, what would your "dream weight" be? ________

At what weight do you feel you would be happy? _______ What weight would be "acceptable" to you? ______

At what weight (less than your current weight) would you still be disappointed? ________

What weight do you have in mind to achieve as your "goal weight" through this program? ________

Please list two reasons that you have decided to lose weight:

1. _____________________________________ 2. _____________________________________

Please list the factors you feel have contributed to your current weight (check all that apply):

Weight gain following an injury
Pregnancy
Poor food choices
Stress related eating
Slow metabolism
Lack of exercise
Binge eating
Late night snacking

Other (please list): ____

Please indicate which methods you have used to lose weight in the past (check all that apply):

Low carb diet (Atkin's/South Beach)
Weight Watchers™
TOPS™
Jenny Craig™
Nutri-System™
VLCD (hospital or clinic based)
Exercise alone
Self-directed diet
Herbalife™
Metabolife™
Surgery (stapling)
Surgery (bypass)

Other (please list): ____

Please indicate which weight loss medications you have used in the past (check all that apply):

Phentermine
Fenfluramine
Dexfenfluramine
Phen/Fen combination
Meridia®
Xenical®
Wellbutrin
Other (list): ____________________

HENRY FORD WEIGHT MANAGEMENT PROGRAM

Your initials_______

Have you successfully lost weight in the past? Yes No

If yes, what approach did you use: ____

Following your most recent weight loss, did you regain any weight? (choose one)

No weight regained	I regained all of it
I regained some weight	I regained it all plus more
I have never lost weight	I have continued to lose weight

If you regained weight, what do you think was the primary reason? ______________________________

____

On a scale of 1 to 10, how motivated are you are to lose weight at this time compared to your previous efforts at weight loss:

(not very motivated) (extremely motivated)

Please circle your answer: 1 2 3 4 5 6 7 8 9 10

On a scale of 1 to 10, how certain are you that you will remain committed to your weight loss program for the time it requires to reach your weight loss goal:

(not very committed) (totally committed)

Please circle your answer: 1 2 3 4 5 6 7 8 9 10

On a scale of 1 to 10, considering all outside factors in your life (stress, family, work, money) to what extent can you tolerate the effort to stick to your weight loss program at this time:

(can not tolerate) (can easily tolerate)

Please circle your answer: 1 2 3 4 5 6 7 8 9 10

When would you be willing to start your weight loss program? (choose one)

I'm ready to start today!	I will be ready in 2 months
I will be ready in a week or two	I will be ready in 3 month
I will be ready in a month	I'm not sure I can do this

Are you pregnant? Yes No NA Are you planning a pregnancy in the near future? Yes No NA

Are you currently breast feeding (lactating)? Yes No NA

Has any member of your immediate family (parents, brothers, sisters) ever had: (choose all that apply):

Cardiovascular disease	Breast Cancer
Diabetes (type 1 or type 2)	Colon Cancer
Gout	Lung Cancer
High Blood Pressure	Ovarian Cancer
Obesity	Prostate Cancer
Osteoarthritis	Other Cancer
Sleep Apnea	Alcoholism
Stroke	Other (list): ______________________

HENRY FORD WEIGHT MANAGEMENT PROGRAM

Your initials_______

Indicate which of the following conditions you have suffered or currently suffer from (choose all that apply):

Heart Attack	Osteoarthritis
Heart Failure	Sleep Apnea
Heart Valvular Disease	Type 1 Diabetes
High Blood Pressure	Type 2 Diabetes
Neurological Disease	Thyroid Disease
Bowel Disease	Depression
Kidney Disease	Anemia
Liver Disease	Gout
Cancer (list types below)	Other (list types below)

Other diseases or illnesses: ___________________________

Types of cancer: ___________________________________

Indicate what types of medication you are currently taking (prescription and over the counter - choose all that apply):

NONE	for Depression
for Weight Loss	for Anxiety
for High Blood Pressure	for Sleep
for Heart Disease	for Hypothyroidism
for Birth Control	for Gout
for Hormone Replacement	for Allergies
for Diabetes	OTHER

List ALL medication you are currently taking in the box below (prescription and over the counter, including vitamins – include the name of the medication, dosage, and frequency for each medicine):

List any medication allergies: ____

List any food allergies: ____

List any hospitalizations for surgery, major illness or injury that required an overnight stay (include date):

____

Smoking? (choose one):

Never smoked   Quit smoking   Less than pack/day   Up to 2 packs/day   More than 2 packs/day

If you smoke or used to smoke, How long? _________ yrs.   If you quit smoking, when? (date)__________

Do you use alcohol? (choose one):

Never   Quit drinking   Less than 3 drinks/week   Up to 14 drinks/week   More than 14 drinks/week

HENRY FORD WEIGHT MANAGEMENT PROGRAM

Your initials_______

Indicate what symptoms you are currently experiencing (choose all that apply):

Vision problems	Vaginal bleeding
Hearing problems	Unusual skin lumps
Swallowing problems	Breast lumps or changes
Shortness of breath	Pain in hands
Chest pain	Pain in feet
Palpitations	Pain in hips
Wheezing	Pain in knees
Indigestion/Nausea	Pain in back
Lactose intolerance	Pain in neck
Abdominal pain	Pain in shoulder
Diarrhea	Pain in elbow
Constipation	Skin rash
Vomiting	Numbness/Tingling
Rectal Bleeding	Trouble walking

Other (list): ___________________________________

Do you have a history of: (choose all that apply)

Anorexia	Never	Past	Present
Bulemia	Never	Past	Present
Binge eating	Never	Past	Present
Incest/sexual abuse	Never	Past	Present

Please complete the following sentences by circling the appropriate word (in bolded italics):

I ***have*** | ***have not*** been overweight since childhood.

I ***have never*** | ***have*** weighed much more than I do now.

It ***has*** | ***has not*** been a problem for me to lose weight.

Life ***is*** | ***is not*** easy for me now.

There ***are*** | ***are not*** stresses in my life.

I ***can not*** | ***can*** reduce the amount of rich fatty foods that I eat right now.

I ***do*** | ***do not*** miss breakfast often.

I ***do*** | ***do not*** miss lunch often.

I ***do*** | ***do not*** miss dinner often.

I ***do*** | ***do not*** eat high-fat snacks in the evening.

I ***do*** | ***do not*** eat large amounts of food at one time.

I ***do*** | ***do not*** feel that my eating is out of control at times.

I ***have*** | ***have not*** purged, vomited, or used laxatives after eating.

I ***do*** | ***do not*** drink alcohol every day.

I ***do*** | ***do not*** feel depressed, sad, or blue.

I ***have little*** | ***have a normal*** interest in doing things.

HENRY FORD WEIGHT MANAGEMENT PROGRAM

Your initials_______

Please complete the following with either a written answer or by circling the appropriate answer:

What are your 2 biggest barriers (or challenges) to changing your diet?

1. ________________________________ 2. ________________________________

How is your appetite? Excellent | Good | Fair | Poor

Have you made recent changes in your diet? Yes No

If yes, what changes have you made? ________________________________

____

Are you or have you ever been on a special diet? Yes No

If yes, describe the special diet? ________________________________

____

How many times have you tried to lose weight?

Never Once or twice More than 5 times I never stop trying to lose

Do you eat only when you are hungry? Yes No

Do you usually stop eating when you are full? Yes No

How many meals per week do you eat at home? (by meal type)

Breakfast ______ Lunch ______ Dinner ______

When you do not eat at home, where do you usually eat? ________________________________

____

Who does the food shopping for the meals you eat at home? ________________________________

Who prepares the meals you eat at home? ________________________________

Do you eat differently than the rest of the family? Yes No

If yes, describe the difference? ________________________________

____

Please respond to the reply that comes closest to how you have been feeling in the past week. Don't take too long over your replies. Your immediate reaction to each item will probably be more accurate than a long thought out response. Indicate your answers by placing a check mark (only one per question) in the appropriate box.

I feel tense or "wound up":
most of the time a lot of the time from time to time, occasionally not at all

I still enjoy the things I used to enjoy:
definitely as much not quite so much only a little hardly at all

I get sort of frightened feeling as if something awful is about to happen:
very definitely and quite badly yes, but not too badly a little, but it doesn't bother me not at all

I can laugh and see the funny side of things:
as much as I always could not quite so much now definitely not so much now not at all

HENRY FORD WEIGHT MANAGEMENT PROGRAM

Your initials_______

Please respond to the reply that comes closest to how you have been feeling in the past week. Don't take too long over your replies. Your immediate reaction to each item will probably be more accurate than a long thought out response. Indicate your answers by placing a check mark (only one per question) in the appropriate box.

Worrying thoughts go through my mind:
a great deal of the time | a lot of the time | from time to time but not too often | only occasionally

I feel cheerful:
not at all | not often | sometimes | most of the time

I can sit at ease and feel relaxed:
definitely | usually | not often | not at all

I feel as if I am slowed down:
nearly all the time | very often | sometimes | not at all

I get a sort of frightened feeling like "butterflies in the stomach":
not at all | occasionally | quite often | very often

I have lost interest in my appearance:
definitely | I don't take so much care as I should | I may not take quite as much care | I take just as much care as ever

I feel restless as if I have to be on the move:
very much indeed | quite a lot | not very much | not at all

I look forward with enjoyment to things:
as much as I ever did | rather less than I used to | definitely less then I used to | hardly at all

I get sudden feelings of panic:
very often indeed | quite often | not very often | not at all

I can enjoy a good book or radio or TV program:
often | sometimes | not often | very seldom

In accordance with the NOTICE OF PRIVACY PRACTICES that you previously read and signed at Henry Ford Hospital, this notice informs you that the Henry Ford Weight Management Program will share the information contained in this document and other information gathered during your participation in the Weight Management Program with the company betterMD.net, Inc. By signing below you are indicating that you previously read the above stated notice and are fully aware of, and will allow, the sharing of your weight management related information with betterMD.net, Inc.

Signature: ____________________________________ Date: _____________