YOUR FIRST APPOINTMENT

We value your time and want to help make your first appointment more efficient. Enclosed are a New Patient Information Form, a Medical History, and a Weight History. Please complete these forms, plus the food questioner, food list, food list by type forms and bring them with you to your first appointment. Please read and follow these instructions:

1. Bring the completed forms to your first visit.
2. Please be on time. This allows us to make the best use of your time and is considerate of other patients. Being more than 15 minutes late will result in rescheduling your appointment. Please give at least 24 hours notice for change or cancellation of your appointment.
3. We do not accept insurance. Payment is due at the time of service. We accept cash and all major credit cards. The charge for your first visit will be $263.
4. We require that you have an EKG which will be done on your first visit. We ask that you do not wear lotion, body oil, Vaseline, or any other products that could make your skin feel oily. We need your skin clean and free of products the day of your first visit.
5. We will be doing a body composition analysis on your initial visit. This will give us your weight and BMI (Body Mass Index). Please wear shoes that are easy to take off.
6. You will be offered to have a beginning weight photo shoot, please bring something you can change into that will show YOU for comparison at the end of your program.
7. We require blood work on all new patients. On your first visit, you will receive a prescription for these tests or chose to have your labs done through our office (additional cost required upfront). Please get this blood work completed by your second visit. You will be responsible for any charges not covered by your particular insurance. To ensure the most accurate results, please fast for 12 hours prior to your blood draw. You should have nothing to eat during that time. Drink plenty of water and take your medications during your fasting hours. It takes 2 to 3 days for the results of your tests to be faxed to us, so please have your blood work done as soon as possible so Bradley Hilliard-Lythgoe, ARNP can review the results with you at your second visit with us.
8. On your first and second visits to Spokane Wellness Center, we request that you make arrangements for childcare. This is an important time for you and Bradley Hilliard-Lythgoe, ARNP to review your history, develop your own personalized plan for weight loss, and to discuss your test results.

We look forward to meeting you. If you have questions, please call 509-904-1644.

PATIENT FINANCIAL POLICY

Financial Policy:

I will be paying today by ☐ Cash ☐ Credit Card

I agree that I have come to Spokane Wellness Center to assist me in losing weight. I understand that by joining the weight management program I am agreeing to regular weekly visits, following the instructions I am given and that I will be responsible for full payment each week. For your convenience, we accept Cash, Visa, MasterCard, Discover, and American Express. 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 am looking forward to being thinner and healthier and commit to my share of the work ahead.

I have read and understand and agree to the Financial Policy of Spokane Wellness Center.

Patient's Signature

Date

WEIGHT HISTORY

Height:_____Current Weight:_____Goal Weight: _____

How long have you been trying to lose weight?

What has been your heaviest weight?

When were you that weight? (at what age?)

As best you can recall, what was your body weight at each of the following ages?

Grade School_____High School_____College_____Ages 20-29_____30-39_____40-49_____50-59 _____

At what age did you start trying to lose weight? _____

What do you think is the cause of your weight problem? _____

Have you ever stayed the same weight for 10 years or more? YES NO

Are any members of your household overweight? YES NO

If yes, please list relationship and details _____

What is your motivation for wanting to lose weight? Check all that apply.

- ☐ Don't like the way I look
- ☐ More energy
- ☐ Better work opportunities
- ☐ More mobility
- ☐ Attend a wedding/graduation
- ☐ Attend a reunion
- ☐ Perform better
- ☐ Feel more confident socially
- ☐ Reduce medications
- ☐ Upcoming event
- ☐ Clothes don't fit anymore
- ☐ Improve health
- ☐ Feel better
- ☐ Want to wear smaller size
- ☐ Upcoming vacation
- ☐ Look better
- ☐ Live longer
- ☐ Look more attractive for my partner
- ☐ Want to wear more stylish clothing
- ☐ Other (please describe)

What dietary problem areas apply to you? Check all that apply.

- ☐ Skipping meals
- ☐ Craving carbohydrates
- ☐ Large portion size
- ☐ Too much alcohol
- ☐ Frequent snacking
- ☐ Binging on food
- ☐ Eating foods too high in fat
- ☐ Eating too many meals in restaurants
- ☐ Eating for reasons other than hunger
- ☐ Eating before going to bed
- ☐ Making yourself vomit after meals

What weight loss programs have you previously participated in?

		RESULTS?	LENGTH OF PARTICIPATION?
	WEIGHT WATCHERS		
	JENNY CRAIG		
	SLIM FAST		
	ATKINS		
	SOUTH BEACH		
	LA WEIGHT LOSS		
	NUTRISYSTEMS		
	LINDORA		
	OVEREATERS ANONYMOUS		
	LIQUID DIETS (EG. OPTIFAST)		
	DIET PILLS: MERIDIA, XENICAL		
	DIET PILLS: PHEN-FEN, REDUX		
	OTC DIET PILLS		
	OBESITY SURGERY		
	OTHER		

Have you maintained any weight loss for up to one year on any of these programs? YES NO

What did you learn from these programs regarding your weight? _____

_____

_____

_____

Why did these programs not meet your expectations? What did not work? _____

_____

_____

Please answer the following questions on a scale of 1 - 5.

SCALE: LEAST 1 2 3 4 5 MOST

- ☐ Your level of interest in losing weight is?
- ☐ Are you ready for lifestyle changes to be part of your weight control program?
- ☐ How much support can your family provide?
- ☐ How much support can your friends provide?
- ☐ How confident are you that you can lose weight this time?
- ☐ How confident are you that you can keep weight off this time?

FOOD ALLERGIES: _____

FOOD DISLIKES: _____

FOOD YOU CRAVE: _____

How much do you smoke daily? _____

How much caffeine do you ingest daily? _____

How much alcohol do you drink? _____

DO YOU

		TYPICAL FOODS	
	EAT BREAKFAST		
	EAT LUNCH		
	EAT DINNER		
	EAT BETWEEN MEALS		
	EAT AT NIGHT		
	EAT WHEN STRESSED		

ACTIVITY LEVEL (CHECK ONLY ONE)

- ☐ Inactive - No regular physical activity with a sit-down job
- ☐ Light activity - No organized physical activity during leisure time
- ☐ Moderate activity - Occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
- ☐ Heavy activity - Consistent lifting, stair climbing, heavy construction, or regular participation in jogging, swimming, cycling or active sports at least 3 times per week
- ☐ Vigorous activity - Participation in extensive physical exercise for at least 60 minutes per session 4 times per week

BEHAVIOR STYLE (CHECK ONLY ONE)

- ☐ You are always calm and easygoing
- ☐ You are usually calm and easygoing
- ☐ You are sometimes calm with frequent impatience
- ☐ You are seldom calm and persistently driving for advancement
- ☐ You are never calm and have overwhelming ambition
- ☐ You are hard driving and can never relax

THIS INFORMATION WILL ASSIST US IN IDENTIFYING YOUR PARTICULAR PROBLEM AREAS. THANK YOU FOR YOUR TIME AND PATIENCE IN PROVIDING THIS INFORMATION.

DRT

For each question, circle the answer that best describes how you feel:

Section 1: Goals and Attitudes

1. Compared to previous attempts, how motivated to lose weight are you this time?

1	2	3	4	5
Not at all Motivated	Slightly Motivated	Somewhat Motivated	Quite Motivated	Extremely Motivated

2. How certain are you that you will stay committed to a weight loss program for the time it will take to reach your goal?

1	2	3	4	5
Not at all Certain	Slightly Certain	Somewhat Certain	Quite Certain	Extremely Certain

3. How certain are you that you will stay committed to a weight loss program for the time it will take to reach your goal?

1	2	3	4	5
Not at all Certain	Slightly Certain	Somewhat Certain	Quite Certain	Extremely Certain

4. Think honestly about how much weight you hope to lose and how quickly you hope to lose it. Figuring a weight loss of 1 to 2 pounds per week, how realistic is your expectation?

1	2	3	4	5
Not at all Certain	Slightly Certain	Somewhat Certain	Quite Certain	Extremely Certain

5. While dieting, do you fantasize about eating a lot of your favorite foods?

1	2	3	4	5
Always	Frequently	Occasionally	Rarely	Never

6. While dieting, do you feel deprived, angry and/or upset?

1	2	3	4	5
Always	Frequently	Occasionally	Rarely	Never

Section 1 TOTAL SCORE ☐

Section 2: Hunger and Eating Cues

7. When food comes up in conversation or in something you read, do you want to eat even if you are not hungry?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

8. How often do you eat because of physical hunger?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

9. Do you have trouble controlling your eating when your favorite foods are around the house?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

Section 2 TOTAL SCORE ☐

Section 3: Control Over Eating

If the following situations occurred while you were on a diet, would you be likely to eat **more** or **less** immediately afterward and for the rest of the day?

10. Although you planned on skipping lunch, a friend talks you into going out for a midday meal?

1	2	3	4	5
Would Eat Much Less	Would Eat Somewhat Less	Would Make NO Difference	Would Eat Somewhat More	Would Eat Much More

11. You "break" your diet by eating a fattening, "forbidden" food.

1	2	3	4	5
Would Eat Much Less	Would Eat Somewhat Less	Would Make NO Difference	Would Eat Somewhat More	Would Eat Much More

12. You have been following your diet faithfully and decide to test yourself by eating something you consider a treat.

1	2	3	4	5
Would Eat Much Less	Would Eat Somewhat Less	Would Make NO Difference	Would Eat Somewhat More	Would Eat Much More

Section 3 TOTAL SCORE ☐

Section 4: Binge Eating and Purging

13. Aside from holiday feasts, have you ever eaten a large amount of food rapidly and felt afterward that this eating incident was excessive and out of control?

YES = 2 NO = 0

14. If you answered YES to #13, how often have you engaged in this behavior during the last year?

1	2	3	4	5	6
Less Than Once a month	About Once A Month	A Few Times A Month	About Once A Week	About 3 Times A Week	Daily

15. Have you ever purged (used laxatives, diuretics or induced vomiting) to control your weight?

YES = 5 NO = 0

16. If you answered YES to #15, how often have you engaged in this behavior during the last year?

1	2	3	4	5	6
Less Than Once a month	About Once A Month	A Few Times A Month	About Once A Week	About 3 Times A Week	Daily

Section 4 TOTAL SCORE ☐

Section 5: Emotional Eating

17. Do you eat more than you would like to when you have negative feelings such as anxiety, depression, anger or loneliness?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

18. Do you have trouble controlling your eating when you have positive feelings – do you celebrate feeling good by eating?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

19. When you have unpleasant interactions with others in your life, or after a difficult day at work, do you eat more than you'd like?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

Section 5 TOTAL SCORE ☐

Section 6: Exercise Patterns and Attitudes

20. How often do you exercise?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

21. How confident are you that you can exercise regularly?

1	2	3	4	5
Not at all Confident	Slightly Confident	Somewhat Confident	Highly Confident	Completely Confident

22. When you think about exercise, do you develop a positive or negative picture in you mind?

1	2	3	4	5
Completely Negative	Somewhat Negative	Neutral	Somewhat Positive	Completely Positive

22. How certain are you that you can work regular exercise into your daily schedule?

1	2	3	4	5
Not at all Certain	Slightly Certain	Somewhat Certain	Quite Certain	Extremely Certain

Section 6 TOTAL SCORE ☐

CONSENT FOR PHOTOGRAPHS

I hereby authorize Spokane Wellness Center staff to take my photograph during my initial consultation, during and at the end of my weight loss program. I understand that these pictures are for office purposes only, and that they will be kept in medical record at all times.

I DO_____DO NOT_____(Please initial one) give permission for my photographs to be used by Spokane Wellness Center for marketing or educational purposes. I understand that, if used, these photographs will not contain my name or any other identifying information.

_____ _____

Signature Date

_____ _____

Witness Date

Patient Informed Consent for Appetite Suppressants and Participation in a Weight Management Program

I. Procedure and Alternatives:

1. I,_____(patient) authorize Bradley Hilliard-Lythgoe, ARNP to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to, the use of appetite suppressants for more than 12 weeks and, when indicated, in higher doses than the dose indicated in the appetite suppressant labeling.

2. I have read and understand my provider's statements that follow:

"Medications, including the appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter term studies (up to 12 weeks) using the dosages indicated in the labeling."

"As a bariatric provider, I have found the appetite suppressants helpful for periods far in excess of 12 weeks, and at times in larger doses than those suggested in the labeling. As a provider, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer term studies and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses. At Spokane Wellness Center, an appetite suppressant may be used in combination with other appetite suppressants and other supplements."

"Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects (as noted below)."

"As a bariatric provider, I believe the probability of such side effects is out weighted by the benefit of the appetite suppressant use for longer periods of time and when indicated in increased doses. **However, you must decide if you are willing to accept the risks of side effects, even if they might be serious, for the possible help the appetite suppressants use in this manner may give."**

3. I understand it is my responsibility to follow the instructions carefully and to report to the provider treating me for my weight, any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.

INITIALS: _____

4. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.

5. I understand there are other ways and other programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an exchange eating program without the use of the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

I. Risks of Proposed Treatment:

I understand this authorization is given with the knowledge that the use of the appetite suppressant's for more than 12 weeks and in higher doses than the dose indicated in the labeling is considered an "off label" use and involves some risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heartbeat and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

I understand that if I develop side effects from the diet or the medication, I will discontinue the diet and / or the medication(s) and notify the medical staff of Spokane Wellness Center as soon as possible. I also understand that if the problem is worrisome or severe, I will go the nearest Emergency room or see my primary care provider as soon as possible. (Take your medications with you.)

II. Risks Associated with Being Overweight or Obese:

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am.

III. No Guarantees:

I understand that much of the success of the program will depend on my own efforts and that there are no guarantees or assurances that the program will be successful. I also understand that I will have to continue watching my weight all my life if I am to be successful.

IV. Pregnancy:

If a female, my signature confirms that I am not pregnant, do not plan to get pregnant, and I will take all necessary precautions to prevent pregnancy during the time I will be taking appetite suppressants. If I become pregnant, I will stop the medication immediately and notify Spokane Wellness Center.

INITIALS:_____

V. Payment, Insurance, Refunds & Prescriptions:

By consenting to treatment, I agree to pay in full for all visits and charges at the time of each visit.

I understand that your services are not reimbursed by insurance and that you do not provide or complete claim forms for insurance purposes. I understand that no refunds are given at any time for any reason. I also understand that the medications dispensed to me during my weekly visits are included for quality assurance and my convenience: however, I may request a written prescription for my weekly dose of my medication.

VI. Property of Spokane Wellness Center:

I understand that all written materials describing your program or any of its parts, all applicable trademarks, copyrights and other intellectual property in or to your program and related materials are and remain your absolute property. I acknowledge that I am purchasing a non-exclusive, nontransferable license to use your program and the related written materials for my own use, and that I have no right to duplicate or to sell, lend or otherwise transfer to any other person or to make any commercial use of the Spokane Wellness Center program or related written materials. I may not modify, publish, distribute, perform, participate in the transfer or sale, create derivative work of, or in any way exploit any of the content, in whole or in part.

INITIALS: _____

VII. Patient's Consent:

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my provider regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants. My signature further confirms that I do not have a history of alcohol abuse, drug abuse, schizophrenia, severe manic-depressive illness, or history of any eating disorder, since these conditions constitute a contraindication to the use of appetite suppressants. I agree not to take any other appetite suppressants, other medications, or injections other than those listed on my medical history form or those prescribed by Bradley Hilliard-Lythgoe, ARNP. I agree to inform Bradley Hilliard-Lythgoe, ARNP of any changes in my medications.

WARNING

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK YOUR PROVIDER NOW BEFOR SIGNING THIS CONSENT FORM.

DATE: _____ TIME: _____

PATIENT: _____ WITNESS: _____

VIII. PROVIDER DECLARATION:

I have explained the contents of this document to the patient and have answered all the patient's related questions, and, to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies and the risks of continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving the appetite suppressants in the manner indicated above.

_____

Provider's Signature

INITIALS: _____