Elina Medical Weight LOSS

Initial Assessment

Date:______________________________

Please Circle: Mr / Mrs / Ms / Miss / Master/ Other

Date of Birth:__________________________

First Name: ____________________________________

Middle Name:______________________________

Surname:______________________________________

Preferred Name: ____________________________

Home:_____________________ Work:__________________________ Mobile:____________________________

Email:____

Address:____

☐ If you don't want to receive SMS reminders. Cross Box here

This is how the clinic reminds you that you are due for things. i.e. Immunisation/ results

Suburb/City:___________________________________Post Code:_________________

Medicare Card No:_____________________________________

Ref No:______

Exp Date:___________________

3125 47247 5
1 John Smith
2 Jane Smith
Valid to 09/2020

Concession (please circle): Pension Veterans Healthcare card Commonwealth Seniors card None

Concession Card No:________________________________Exp Date: __________________

Private Health Insurance (please circle): Basic Hospital Intermediate Top Hospital None

Country of Birth___________________________

Ethnicity_______________________________

Language/s Spoken 1.____________________ 2.____________________

Aborginal/Torres Strait Islander? YES / NO

Interpreter Needed: ☐ Tick if yes

Who is your usual General Practitioner?____

Past Medical History: ____

____

____

Previous Surgery: ____

____

Medications: ____

____

____

Allergies: ____

Food Intolerances/ Prefrences:____

Smoking YES / NO

Occupation:__________________________________

How did you hear about the clinic?

Google ☐ Facebook ☐ Patient of GP Clinic ☐ Our Website ☐ Saw sign out front ☐

☐ Personal recommendation/ by whom_______________________________________

Other:____ Mail out/flyer:________________________________

Next of Kin/ who would we call incase of an Emergency??
Please circle: Mr / Mrs / Miss / Ms
First Name:______________________________________Surname:______________________________________
Address:____ Suburb:___________________________________
Phone Number:________________________________Relationship to the patient:______________________________

PRIVACY STATEMENT – CONSENT FORM

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your healthcare needs.

We require your consent to collect this personal information about you. The privacy policy is available on our website and can be viewed on request.

Please read the following information carefully, and sign where indicated below.

We will use the information you provide in the following ways:

- Administrative purposes in running our medical practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirement
- Deliver to you; appointment reminders, recall notices, health information, practice information and services , results of tests, by SMS, secure email, phone or letters unless you tell us otherwise.
- Disclosure to others involved in your health care, including treating doctors, ancillary practitioners and specialists outside this medical practice. This may occur through referral to other practitioners, or for medical tests and in the reports or results returned to us following the referrals.
- Disclosure to doctors, ancillary practitioners, locums and GP registrars attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes we will note in your record accordingly.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to 'opt out' of any involvement.

I have read the adjacent information and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the healthcare and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these

I understand that if my information is to be used for any purposes other than those outlined at left, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes outlined at left, subject to any limitations on access or disclosure of which I notify this practice.

Name (please print): _____________________________

D.O.B:______/_______/_______

Signature:_______________________________________

Date:______/_______/________

PHYSICAL ACTIVITY

How Active would you say you are currently?:

- ☐ Extemely Inactive or immoble - Your are seated for most or all of the day eg. Wheelchair bound, inactive, couch bound
- ☐ Sedentry - Seated for extended periods throughout the day? Eg. Office Worker
- ☐ Moderately Active - You are an active and on the go kind of person Eg. Work in hospitality, childcare or run approx 1 hour per day
- ☐ Very Active - You do heavy manual labour for a job Eg. Builder, Labourer
- ☐ Extremely active - Eg. Competative marathon runner

SLEEP

On average, how many hours sleep do you get per night?__________hours

Do you snore? __________________________

Has anyone told you that you stop breathing or have choking episodes overnight?___________________________

Do you wake up feeling unrefreshed or can you fall asleep easily during the day?____________________________

WEIGHT HISTORY

What is your heaviest (non pregnant) weight? __________KG

Current Weight ________________Kg

What is your lightest weight? ___________KG

Current Height ________________cm

What is your ideal weight?___________KG

Is there a family history of overweight or obesity?_________________

What weight loss tools have you tried in the past? **(Please Tick all the apply)**

- ☐ Jenny Craig
- ☐ Weight watchers
- ☐ Lite N Easy
- ☐ Michelle Bridges Program
- ☐ Atkins diet
- ☐ 5:2 diet
- ☐ CSIRO total wellbeing diet
- ☐ Paleo
- ☐ Mediterannean diet
- ☐ Very Low Caloric Diet (VLCD) eg. Optifast, Tony Ferguson, Kicstart
- ☐ Diet and Exercise

Medications:

- ☐ Phentermine (Duromine)
- ☐ Orlistat (Xenical)
- ☐ Sibutramine (Reductil)
- ☐ Topirimate (Topamax)
- ☐ Liraglutide (Saxenda)

Weight loss surgery:

- ☐ Gastric banding? When?________________________ Surgeon?________________________________
- ☐ Sleeve gastrecotmy? When?____________________ Surgeon?_____________________________
- ☐ Gastric bypass? When?_________________________ Surgeon?____________________________
- ☐ Other?____

Do you have a history of eating disorders? (eg. Anorexia, Bulimia)__________________________

ALCOHOL

Do you drink alcohol? ___________

If Yes please continue; How often? ________ times per week, _________ times per month

How many drinks do you typically have per day? ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-10 ☐ 10 or more

How often would you drink 6 or more standard drinks in a day?_______________________

Are you concerned about your drinking or would like to find out about options to manage your drinking?

____

HOW READY ARE YOU?

My greatest motivation to control my weight is……

____

____

Please Circle Below:

On a scale of 0-10, how *motivated* are you to control your weight?

0	1	2	3	4	**5**	6	7	8	9	**10**
Not at all Motivated					**Somewhat Motivated**					**Extremely Motivated**

On a scale of 0-10, how confident do you feel that you can manage your weight?

0	1	2	3	4	**5**	6	7	8	9	**10**
Not at all Confident					**Somewhat Confident**					**Extremely Confident**

On a scale of 0-10, how often do you feel stressed, anxious or depressed?

0	1	2	3	4	**5**	6	7	8	9	**10**
None of the time					**Some of the time**					**All of the time**