New You 2.0 Weight Management Program

Initial Evaluation Form (All questions MUST be answered to be considered for the program. Patients are NOT chosen on a first-come, first- served basis. The information you provide will NOT impact your health insurance. Only Allegiance Health Insurance patients can qualify.)

Name _____ Date of Birth_____ Age_____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Occupation _____

Present Weight _____ Present Height _____ Sex: □ Male □ Female

At what age did you begin to develop a significant weight problem? _____

In your **opinion**, what contributes to your excess weight?

□ Portion sizes □ Eating too much fat and sugar □ Stress eating

□ Emotional eating □ Compulsive eating □ Lack of exercise

□ Medications (please list below) □ Lack of knowledge about healthful eating and exercise

Please describe any events you believe are related to your weight gain

_____

Lowest weight as an adult (and when)? _____ **Peak** adult weight (and when)? _____

Other significant weight **gain**? _____ Other significant weight **loss**? _____

Activity growing up: Involved in sports/athletics? □ Yes □ No

Which Sports/Activities? _____

Did your family have dinner together? □ Yes □ No

□ Meat & Potatoes □Pasta □Fried Food □ Fast Food Dessert □ Yes □ No

How many meals do you consume per day? _____

How many snacks do you consume per day? _____

Current medications and supplements

Name	Dose	How often	Start Date	Vitamin/Mineral	OTC (Aspirin, etc)	OTC (Herbal)

Please list allergies to medications and your reaction

_____

_____

Current lifestyle

Please check the appropriate box:

□ Single □ Married □ Divorced □ Widow □ Significant Other

Do you live alone? □ Yes □ No

Do you have children? □ Yes □ No If yes, please list ages _____

Do your children live at home? □ Yes □ No □ N/A

Do you smoke? □ Yes □ No

If yes, number of packs per day _____ number of years _____When did you quit _____

Do you drink alcohol? _____ How many drinks/day _____How often _____

Do you use illicit drugs? □ Yes □ No

If yes, please describe drug, method and frequency of use (e.g. IV, smoke, snort, etc) _____

Do you currently exercise regularly? □ Yes □ No

If yes, what exercise do you perform?_____

How many times per week? _____How long do you exercise each time? _____

Weight Loss History

If treatment was recommended, what have you tried in the past?

□ Lifestyle □ Medication □ Surgery

Lifestyle (Diet and Exercise)

Name of Program	Year Started	How long?	Start Weight	# of lbs lost	Time wt stayed off	# of lbs regained

Weight Loss Medications (Prescription, Over-the-counter, Herbal)

Name of Product	Year started	How long?	Start Weight	# of lbs lost	Time wt stayed off	# of lbs regained

Have you had nutrition counseling? ☐ Yes ☐ No

If yes, please describe _____

Personal Medical History

□ Heart Disease □ Diabetes □ Sexual Dysfunction □ Kidney Disease

□ High Blood Pressure □ GI Disorder □ Polycystic Ovarian Syndrome □ Bariatric Surgery

□ High Cholesterol □ Gout □ Anemia (Gastric bypass, Lap Band)

□ Sleep Apnea □ Arthritis □ Clotting/Bleeding Disorder

□ Asthma □ Osteoporosis □ Cancer

□ Thyroid Disorder □ Urinary Incontinence □ Other _____

Are you currently on a diet for a medical reason? □ Yes □ No

Have you ever had surgery? □ Yes □ No

Please list ALL **surgical** procedures and the approximate date: _____

_____

_____

Are you receiving any psychiatric/psychological services at this time? □ Yes □ No

If yes, by whom_____

Are you currently being treated for depression? □ Yes □No

If yes, by whom _____

Have you ever been diagnosed with an eating disorder? □Yes □ No

If yes, please describe _____

Binge Eating and Purging (Please check the appropriate box to your response)

Aside from holiday feasts, have you ever eaten a large amount of food rapidly and felt that this eating incident was excessive and out of control afterward? □ Yes □ No

If you answered yes to the above question, how often have you engaged in this behavior during the last year? Please check one.

1. Less than once a month □
2. About once a month □
3. A few times a month □
4. About once a week □
5. About three times a week □
6. Daily ☐

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

□ Yes □ No

If you answered yes to the above question, how often have you engaged in this behavior during the last year? Please check one.

1. Less than once a month □
2. About once a month □
3. A few times a month □
4. About once a week □
5. About three times a week □
6. Daily □

Please feel free to use this space for any additional information.

What do you feel your weight may be holding you back from doing?

Approx. How much weight would you like to lose to help reach your goals?

New You Too Weight Management Program

COLLIER COUNTY MED CENTER AGREEMENT

I, _____ (patient's full name), give the medical provider at the Collier County Med Center authority to work as an adjunct with my current Primary Care Physician in managing my medical care. This includes, but is not limited to, modifying my current medications as seen fit based on regular blood draws during the duration of the weight loss program.

_____ (patient's signature)

_____ Date (mm/dd/year)

_____ (provider's signature)

_____ Date (mm/dd/year)

Please Contact Emotional Wellness for an assessment prior to joining New You. **239 659 7751**

Community Health Partners
Physician Hospital Organization

Emotional Wellness

Lisa Fasanella, LMHC

Lisa Fasanella, a licensed mental health counselor, has joined Community Health Partners to assist members in working through issues related to depressed mood, anxiety, relational issues, grief, loss and other common stressors to get you on your path to recovery.
Lisa has over eighteen years of proven, successful leadership in clinical and non-profit arenas. She completed her undergraduate degree in Family Studies at the University of New Hampshire and received her Master's degree from The College of New Jersey in Mental Health Counseling. Lisa is a graduate of Leadership Collier; having worked in Collier County since she moved to Florida in 2005. Lisa is committed to providing excellent clinical counseling and programmatic oversight for this innovative program.

For insured Allegiance Medical Plan members
- **FREE** individual sessions
- Unlimited visits
- Main Campus location for your convenience

For an appointment, call or email Josie Means at 239-659-7751 or jmeans@chealthpartners.com

This is a confidential service.

Community Health Partners
Physician Hospital Organization

Emotional Wellness

Jaime Crossan-DeBres, LCSW

Jaime Crossan-DeBres, a licensed clinical social worker, has joined Community Health Partners to offer services to employees and their children of all ages that are struggling with emotional and behavioral issues. Services for adults and children will include parenting classes, child development educational classes, play therapy, age-appropriate/age-specific services, anti-bullying, healthy relationships curriculum, child anxiety management, trauma focused therapy and services for PTSD. Jaime has over fifteen years of clinical experience. She completed her undergraduate degree in Sociology and Women's Studies from The University of Toronto and received her Master's degree in Social Work from The Florida Gulf Coast University.

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Community Health Partners
Physician Hospital Organization

Emotional Wellness

Anabel Sathan, MSW and LCSW

Anabel Sathan, MSW and a Licensed Clinical Social Work Intern has joined Community Health Partners to assist members in working though issues related to depressed mood, domestic violence, anxiety, healthy relationships, grief, loss and other common stressors to get you on your path to wellness.
Anabel has over five years of clinical experience, most recently in palliative care. She completed her undergraduate degree and graduate degree in Social Work at Florida Gulf Coast University. Anabel is committed to providing excellent clinical counseling and believes therapy to be an empowering tool to help individuals discover their inner strength and reach their potential.

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- Unlimited visits
- Main Campus location for your convenience

For an appointment, call or email Josie Means at 239-659-7751 or jmeans@chealthpartners.com

This is a confidential service.

Please Contact WELLNESS to conduct Initial Nutrition Assessment: **252 8915**

General Medical History & Information

Are you under the care of a physician, chiropractor, or other health care professional for any reason?

If yes, list reason:_____

Are you aware of any disease or disorder that would complicate your participation in a testing or exercise program?_____

Has your doctor ever told you that you have a bone or joint problem that has been or could be made worse by exercise?_____

Are you taking any medications? If yes please indicate the type of medication, dosage, frequency and reason(s) for taking it. _____

Please list any allergies_____

Has your doctor ever said your blood pressure was too high? _____

Are you over age 65? _____ Are **you unaccustomed to vigorous exercise?** _____

Is there any reason not mentioned here why you should not follow a regular exercise program?
If so, please explain _____

Please describe any past or current musculoskeletal conditions you have incurred such as muscle pulls, sprains, fractures, surgery, back pain, or general discomfort:

Head / Neck _____

Upper Back _____

Shoulder / Clavicle _____

Arm / Elbow _____

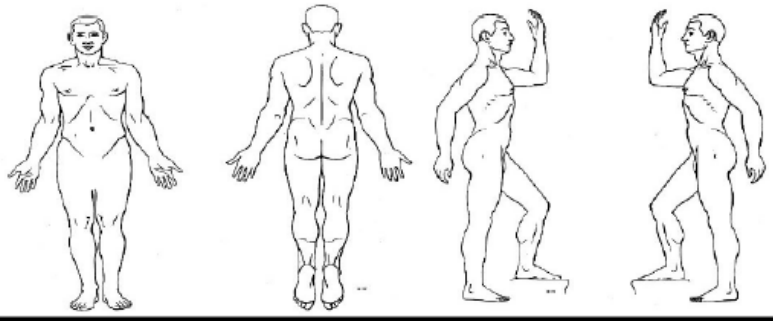
Wrist / Hand _____

Lower Back _____

Hip / Pelvis _____

Thigh / Knee _____

Lower Leg / Ankle / Foot



Please circle any areas of pain, injury, tension, or restriction of movement.

Have you recently experienced any chest pain associated with either exercise or stress?
If so, please explain _____

Do you have a family history of any of the following conditions?

Heart Disease _____ Heart Attack _____ Hypertension _____ Gout _____

Abnormal EKG _____ Asthma _____ High Cholesterol _____ Angina _____

Diabetes _____ Other heart conditions _____

Do you have a family history of cardiovascular disease? If so, how many occurrences and what approximate ages? _____

Are you a smoker? If so, what is your smoking frequency? _____

Are you on any specific food / nutritional plan at this time? _____

Do you take dietary supplements? If yes, please list _____

_____

How many beverages do you consume per day that contains caffeine? _____

Do you experience any frequent weight fluctuations? _____

Have you experienced a recent weight gain or loss? _____

If yes, list change _____Over how long? _____

Your answers to these questions will be discussed with you prior to your session. Thank You.

Bring Food Diary to Nutrition Appt:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6
Breakfast						
Snack						
Lunch						
Snack						
Dinner						
Desserts						
Beverages						

Fill out & Bring to Nutrition Appt
Is there a reason you are seeking weight loss program:

What are your goals about weight control & management :

Your level of interest in losing weight

1 2 3 4 5

Not interested Very Interested

Are you planning to adopt lifestyle changes as part of your weight control program

1 2 3 4 5

No Yes

How much support does your family provide you to reach your weight loss goals

1 2 3 4 5

No support Much Support

How much support do your friends provide?

1 2 3 4 5

No support Much support

What is the hardest part about managing your weight ?

What do you believe will be the most to help you lose weight ?

How confident are you that you can lose weight at this time?

1 2 3 4 5

Not confident Very Confident

New You 2.0 Program Commitment Agreement

The ***New You 2.0*** medically-managed weight loss program has specific expectations for participation. The following outlines your responsibility during the program:

1.) The MedCenter Licensed Nurse Practitioner (ARNP) will coordinate your medical care during program participation. The participants have the responsibility of informing their personal physician of participation in this program. Additionally, participants understand that the *New You* 2.0 team, consisting of the ARNP, Licensed Dietitians, and Licensed Mental Health Counselors will discuss and review each participant's case at monthly meetings

2.) Participants are responsible for scheduling all medical appointments. All missed or cancelled appointments must be re-scheduled within three (3) days of missed/cancelled appointment (excluding weekends/holiday).

Failure to have scheduled medical appointments per ARNP recommendation will result in program termination.

3.) All supplements and pharmacology prescriptions are to be taken as prescribed. Access to is available after program guidelines have been met for 3 consecutive months. **Monthly weight loss is expected with usage of the weight loss medication (4 pounds per month minimum)**. The prescription must be used for consecutive months, as prescribed, and will be cancelled if weight loss is not attained on a monthly basis. The County subsidizes these medications up to $1000 per month per person.

4.) Participants are responsible for scheduling/attending their own initial Emotional Wellness sessions. There is no cost to participants who chose to use the CHP Emotional Wellness counselor. Failure to attend counseling services as referred by the medical professional will cause participants to be dismissed from the program.

5.) Participants are expected to attend the weekly individual sessions with Wellness Team Member. Weekly attendance with presentation of weekly meal plans, exercise logs and a weigh in will be conducted**.**

New You 2.0 Program Guidelines to maintain program enrollment will consist of:

At weekly weigh-ins you will be reviewing

If BMI is ≥ 30 a 4-pound weight loss monthly is expected

If is BMI 25-29 a 2 to 4-pound weight loss monthly is expected

If monthly weight loss per above expectations is not met, then improvement in monthly Inbody result will be allowed to meet program compliance.

- Weekly food records, following meal pattern guidelines established by Dietitian
- Weekly exercise log (Individualized exercise plan designed by fitness trainer)
- Weekly goals specific to individual
- **Exercise is an essential part of your success at attaining & maintaining weight loss. Participants are expected to exercise daily to maximize weight loss results.**

Program Guidelines will also include:

Mandatory Monthly InBody Scan conducted for progress & reassess nutrition plan based on Inbody results

Participants will not share meal plan with others, as they are following a specific meal plan designed for their specific nutrient needs and health goals

*Failure to meet monthly weight loss expectations or monthly improvement in Inbody test values and any of the above guidelines will result in termination of the program.

As a participant, I understand the above program expectations and will abide by them to maintain participation in the New You 2.0 program.

I, _____, agree to the above program participation terms.

_____ _____

Participants' Name (Print Name) Date Witness Name (Print Name) Date

_____ _____

Participants' Signature Date Witness Signature Date

Revised 11/1/2019