Alevia Medical Weight Loss Clinic

Initial Assessment

Today's Date: _____

Please Circle: Mr / Mrs / Ms / Dr /Other

Date of Birth:_____

First Name: _____

Middle Name:_____

Surname:_____

Preferred Name: _____

Home:_____ Work:_____ Mobile:_____

Email:_____

Address:_____

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_____

Language/s Spoken 1._____

Ethnicity_____

2._____

Aboriginal/Torres Strait Islander? YES / NO

Interpreter Needed: ☐ Tick if yes

Who is your usual General Practitioner?_____ Suburb_____

Past Medical History: _____

_____

_____

Previous Surgery: _____

_____

Medications: _____

_____

_____

Allergies: _____

od

Smoking YES / NO

Occupation:_____

How did you hear about the clinic?

Patient of Vermont GP ☐ Facebook ☐ Google ☐ Our Website ☐ Brochure ☐

Sign ☐ Other Doctor/Specialist ☐ Name _____

Personal recommendation/ by whom_____ Other_____

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:_____

WEIGHT HISTORY

What is your heaviest (non pregnant) weight? _____KG

What is your lightest weight? _____KG

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
- ☐ Keto Diet
- ☐ Mediterranean 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 gastrectomy? When?_____ Surgeon?_____
- ☐ Gastric bypass? When?_____ Surgeon?_____

Other?_____

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

PHYSICAL ACTIVITY

How Active would you say you are currently?:

- ☐ Extremely Inactive or immobile - Your are seated for most or all of the day eg. Wheelchair bound, inactive, couch bound
- ☐ Sedentary - 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 1hour per day
- ☐ Very Active - You do heavy manual labour for a job Eg. Builder, Labourer
- ☐ Extremely active - Eg. Competitive marathon runner

SLEEP

Do you have sleep apnoea? Yes/No If yes.. My sleep physician is_____(Skip to next section)

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?_____

REASONS FOR WEIGHT LOSS

Why do you want to lose weight?

_____

_____

READINESS FOR CHANGE

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 *ready* are you to make lifestyle changes to control your weight?

0 1 2 3 4 **5** 6 7 8 9 **10**

Not at all Ready **Somewhat Ready** **Extremely Ready**

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**

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 circumstances.

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:_____/_____/_____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0 = would **never** doze
1 = **slight chance** of dozing
2 = **moderate chance** of dozing
3 = **high chance** of dozing

It is important that you answer each question as best you can.

Situation	Chance of Dozing (0-3)
Sitting and reading	
Watching TV	
Sitting inactive in a public place eg. Meeting, cinema	
As a passenger in a car for half an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	

THANK YOU FOR YOUR COOPERATION

At Alevia Medical Weight Loss, we are here to assist you achieving your weight loss goals.
We want you to know what we provide, the costs involved and how we handle appointment cancellations.
We ask that you read through this form carefully.

What We Provide

We provide weight management services to you, including medical supervision of your weight loss program and associated weight-related health conditions.
You will remain under the care of your regular GP so they are kept up-to-date with your progress and any important changes made for your health.
Please be advised that we cannot provide non weight-related advice during the consultation.

Expenses Not Included In Your Consultation

- Any products recommended, e.g. meal replacements or medications
- Any allied health professionals that your doctor may recommend, such as a psychologist or dietician.

You may see your regular GP to check if you are eligible for a management plan which may cover some of these costs

Your Consent (please tick boxes)

I, _____ consent to the following:
your name

☐ Disclosure of my health information to my GP where appropriate

☐ Clinical Reminders via SMS e.g. abnormal results

☐ Appointment reminders via SMS

☐ I understand and agree to the Late Notice Policy

Please note: you will receive a welcome email.
If you do not wish to receive further emails, press the “Unsubscribe” button at the bottom of the welcome email.

_____
Signature: Date:

levia Appointment Structure & Costs

We know that getting started on your weight loss journey can be difficult, so our doctors have developed a cost-efficient appointment structure, specifically designed to provide you with the support that you need, especially in those first few weeks. Please note that this schedule is only a recommendation, you can choose to make appointments at a frequency that suits you best.

Frequency	***Consultation***	***Appt length***
Initial Consultation	Weight Assessment	30 minute
1 week later	Getting Started	20
1 week later	Weight Review	20
1 week later	How to Keep Weight off Long-Term	20
1 week later	Weight Review	20
1 week later	A Low-Carb Diet for Long-Term Weight Control	20
2 weeks later &	Weight Review	20

All appts are bulk billed