

# Greg Hooper, M.D.

## Weight Management Program

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Remember that the decisions you make today can help you prevent many of the health related problems you may develop starting tomorrow!

Our program is built upon the 3 elements of success. They are diet & nutrition, medication & supplements, and exercise & hydration.

If any one of the components is not followed or utilized the likelihood of success decreases.

The efforts to overcome being overweight or obese are not always easy. That's why we outline the nutritional plan, supplements, and other important factors for your wellness success so that it is at least easy to follow. These components are the core of our weight loss program.

Weight loss is only one of the changes you can make to improve your health, wellness and overall quality of life. Your body composition has a huge impact on the stress that your body endures on a daily basis. Extra weight affects your heart, muscles, joints, and many other parts of your body and when you lose weight you will see and feel positive changes.

During your visit today with our new patient consultant and the physician, they are going to assess your risk factors and total wellness so that you will not only look and feel great once you reach your healthy weight, but you will also be much healthier than you are today.

You've taken a huge step today by coming to us. Now we ask that you follow the treatment plan developed by our trained staff so that together we can help you achieve your goals.



**THE 3 ELEMENTS OF SUCCESS**

**You can't afford to wait until tomorrow to start becoming healthier today!**

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### Patient Information (Please Print)

<b>FIRST NAME</b>	<b>LAST NAME</b>

<b>DATE OF BIRTH</b>	<b>AGE</b>	<b>GENDER</b>	<b>SOCIAL SECURITY #</b>
		<input type="checkbox"/> Male <input type="checkbox"/> Female	

<b>STREET ADDRESS</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>

<b>EMPLOYER</b>	<b>OCCUPATION</b>

<b>WORK PHONE</b>	<b>HOME PHONE</b>
Can we leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No	Can we leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>CELL PHONE</b>	<b>EMAIL ADDRESS</b>
Can we leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>EMERGENCY CONTACT (Last Name, First Name)</b>	<b>PHONE NUMBER</b>

Supporting you in your journey of weight loss and maintenance is very important to us. Therefore, from time to time, we may wish to send you information, samples or special offers that we may feel may be of interest to regarding Dr. Greg Hooper's Weight Management Program and/or Zone Wellness. We may also contact you in relation to consumer research, marketing and customer surveys. If you would rather not receive additional information and/or offers, please do not check the box below.

**PRIVACY:** Your information will be kept strictly confidential and not provided to any third parties.

Yes, I would like to receive such information & offers by postal mail

Yes, I would like to receive such information & offers by phone

Yes, I would like to receive such information & offers by email

<b>How did you learn about the program?</b>	
<input type="checkbox"/> Patient Referral	<input type="checkbox"/> Newspaper (Please Identify):
<input type="checkbox"/> Magazine (Please Identify):	<input type="checkbox"/> Television (Please Identify):
<input type="checkbox"/> Other (Please Describe):	<input type="checkbox"/> Internet

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### Weight History

NAME	DATE

Height:	Current Weight:	What is your desired weight:
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How long have you been trying to lose?

What has been your heaviest weight?

When were you that weight? (record your age)

When did you first become overweight?

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

\_\_\_\_\_

\_\_\_\_\_

Have you ever stayed the same weight for ten (10) years or more?  Yes  No

Are any members of your household overweight?  Yes  No

If yes, please list relation and details...

\_\_\_\_\_

\_\_\_\_\_

**What is your motivation for treatment in our weight loss & wellness program?**  
Check all that apply.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Don't like the way I look<br><input type="checkbox"/> More energy<br><input type="checkbox"/> Better work opportunities<br><input type="checkbox"/> More mobility<br><input type="checkbox"/> Attend a wedding/graduation<br><input type="checkbox"/> Reduce Pain<br><input type="checkbox"/> Perform better | <input type="checkbox"/> Clothes don't fit anymore<br><input type="checkbox"/> Improve health<br><input type="checkbox"/> Feel better<br><input type="checkbox"/> Want to wear smaller sizes<br><input type="checkbox"/> Detoxify the body<br><input type="checkbox"/> Look better<br><input type="checkbox"/> Live longer | <input type="checkbox"/> Increase self confidence<br><input type="checkbox"/> Lower blood pressure<br><input type="checkbox"/> Look & feel younger<br><input type="checkbox"/> Control blood sugar levels<br><input type="checkbox"/> Reduce medications<br><input type="checkbox"/> other (please describe): |
|---|--|---|
- \_\_\_\_\_
- \_\_\_\_\_

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In order to assist you in achieving your weight loss goal, please check the programs that you have previously participated in. Please list under comments if you were successful in obtaining your goal, and if not why the program did not meet your expectations.

Name of Program	Results?	Why this program fell short of your expectations...
<input type="checkbox"/> Weight Watchers	_____	_____
<input type="checkbox"/> Jenny Craig	_____	_____
<input type="checkbox"/> Slim Fast	_____	_____
<input type="checkbox"/> Atkins	_____	_____
<input type="checkbox"/> South Beach	_____	_____
<input type="checkbox"/> L A Weight Loss	_____	_____
<input type="checkbox"/> Nutri System	_____	_____
<input type="checkbox"/> Lindora	_____	_____
<input type="checkbox"/> Other	_____	_____

**Do you exercise? If so, how often do you exercise?**

Never  
  Rarely  
  Daily  
  4-5 times a week  
  2-3 times weekly  
  once a week

**What is your exercise routine?**

Check all that apply.

- |   |  |
|---|--|
| <input type="checkbox"/> Walking                  | <input type="checkbox"/> Bicycling                         |
| <input type="checkbox"/> Swimming                 | <input type="checkbox"/> Yoga                              |
| <input type="checkbox"/> Dancing                  | <input type="checkbox"/> Sports (basketball, tennis, etc.) |
| <input type="checkbox"/> Aerobics                 | <input type="checkbox"/> Strength training                 |
| <input type="checkbox"/> Pilates                  | <input type="checkbox"/> Elliptical                        |
| <input type="checkbox"/> Stairmaster              | <input type="checkbox"/> Treadmill / Jogging               |
| <input type="checkbox"/> other (please describe): |  |

\_\_\_\_\_

\_\_\_\_\_

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### Medical History

Family History (If blood relative has suffered the following, please indicate relationship.)			
Heart Attack		Arthritis	
Cancer		Diabetes	
Hypertension		Obesity	
Stroke		Glaucoma	
Epilepsy		Other	

Have you ever been hospitalized? If yes, when and why?	
Year	Illness or Operation

Medications (Please list the medications you are currently taking, and as needed.)			
Medication	Dosage	How Often	Reason

Allergies (Please list any medications or food that you are allergic to.)	

Medical History								
Yes	No		Yes	No		Yes	No	
		Loss of hearing			Hemorrhoids			Anemia
		Ringing in ears			Hernia			Immune disorders
		Ear infections			Gall bladder			Alcohol abuse
		Bad vision			Sudden weight loss			Drug abuse
		Glaucoma			Liver disease			Hypertension
		Nose bleeds			Back pain			Heart disease
		Sinus trouble			Joint pain			Thyroid disease
		Sore throat			Broken bones			Cancer
		Allergies			Dizzy spells			Diabetes
		Hoarseness			Fainting spells			Stroke
		Pneumonia			Memory loss			Osteoporosis
		Bronchitis			Insomnia			GERD
		Asthma			Nervousness			Rashes
		Short of breath			Depression			Chicken pox
		Tuberculosis			Phobias			Mumps/measles
		Heart murmur			Manic depressive			Polio
		Palpitations			Anxiety			Are you pregnant?
		Irregular pulse			Schizophrenia			Could you be Pregnant?
		Swollen ankles			Bulimia			Are you breast feeding?
		Chest pain			Anorexia			Other:
		Loss of appetite			Other eating disorders			
		Indigestion			Frequent urination			
		Stomach ulcers			Kidney disease			
		Diarrhea			Prostate disease			
		Constipation			Headaches			
		Bloody/tarry stools			Fatigue			

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<b>Supplements (Please list the supplements you are currently taking, i.e. vitamins, fish oil, etc...)</b>			
Supplement & Brand Name	Dosage	How Often	Reason

## Wellness Goals

<b>Which of the following supplements, or products, would you like to incorporate into your wellness Plan?</b>		
Check all that apply.		
<input type="checkbox"/> Cardiovascular System	<input type="checkbox"/> Immune System	<input type="checkbox"/> Hormone Therapy
<input type="checkbox"/> Joints	<input type="checkbox"/> Depression	<input type="checkbox"/> Weight Maintenance
<input type="checkbox"/> Bones	<input type="checkbox"/> Digestive System	<input type="checkbox"/> Health Related Foods
<input type="checkbox"/> Prostate	<input type="checkbox"/> Sexual Activity	<input type="checkbox"/> DNA Testing
<input type="checkbox"/> Cognitive System (Mind)	<input type="checkbox"/> Detoxifying the body	<input type="checkbox"/> Anti-Aging
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Testosterone Levels
<input type="checkbox"/> Beauty/Hair/Skin	<input type="checkbox"/> Menopause	<input type="checkbox"/> other (please describe):
_____		
_____		

Do you feel like your health is improving or declining?
If you could take steps to improve your health for the long term, would you? <input type="checkbox"/> Yes <input type="checkbox"/> No
What is your #1 health concern?
What changes to your current health are the least important to you?
If you could change one thing today about your weight or wellness what would it be?
_____
_____
Do you have others in your family who have wellness concerns as well? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please list relation and details...
_____
_____