



**\*Please note: To provide appropriate care forms MUST be completed prior to initial visit.**

<b>Patient Information</b>		<b>Name</b>	<b>Date of Birth</b>	<b>Gender (circle one)</b> Male - Female
<b>Address / City / State / ZIP</b>				
<b>Home Phone</b>		<b>Cell Phone</b>		<b>Work Phone</b>
<b>May we leave a voicemail Y/N</b>		<b>May we text you Y/N</b>		<b>May we email you Y/N</b>
<b>E-mail address</b>			<b>Marital Status</b> Single - Married - Divorced - Widow - Other	
<b>Employer (if applicable)</b>			<b>Spouse's Employer (if applicable)</b>	
<b>Parent or Guardian (Name and Date of Birth)</b>			<b>Parent or Guardian (Phone and Relationship)</b>	
<b>Emergency Contact (Name and Date of Birth)</b>			<b>Emergency Contact (Phone and Relationship)</b>	
<b>Referral Source (circle one)</b> Family/Friend - Physician - Website - Web ad - Radio/TV ad - Print ad - Insurance company - Other: _____				
<b>Physician Name (if referred)</b>				
<b>Physician Office/Specialty</b>				

**The information provided is correct to the best of my knowledge. My signature below authorizes CENTRA to communicate with me via email, phone, or other means indicated.**

**Signature\*:** \_\_\_\_\_ **Date:** \_\_\_\_\_



<b>Physician Information</b>	Primary Care Physician (Name)	
Location (city, state)	Date of last visit	Date of next visit
Have you had lab tests in the last 3 months? Yes No (If yes, please bring them to your initial visit or notify us so we may request these results.)		

<b>Pharmacy Information</b>	Preferred Pharmacy	
Location (city, state)	Phone number	

<b>Insurance Information</b>	Policyholder Name (if other than patient)	
Primary Insurance (i.e. BC/BS, Aetna, etc.)	Primary Insurance Phone #	
ID / Policy Number	Group Number	
Secondary Insurance Policyholder Name (if other than patient)		
Secondary Insurance (if applicable)	Secondary Insurance Phone #	
ID / Policy Number	Group Number	

The information provided is correct to the best of my knowledge. My signature below authorizes CENTRA to communicate with me via email, phone, or other means indicated.

Signature (parent/guardian)\*: \_\_\_\_\_ Date: \_\_\_\_\_

NAME: \_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_ DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_



Medical History		You may not be familiar with some terms, but mark all that apply.	
CONDITION	MANAGEMENT (Check all that apply)	CONDITION	MANAGEMENT (Check all that apply)
<input type="checkbox"/> Type 2 Diabetes	<input type="checkbox"/> Diet controlled <input type="checkbox"/> Oral Medication <input type="checkbox"/> Insulin	<input type="checkbox"/> Heart Disease (type: _____)	<input type="checkbox"/> Medication <input type="checkbox"/> Hospitalization
<input type="checkbox"/> Hypertension (High Blood Pressure)	<input type="checkbox"/> Diet controlled <input type="checkbox"/> Medication Usual reading: ____ / ____	<input type="checkbox"/> Coronary Disease (Heart Attack, Angina)	<input type="checkbox"/> Medication <input type="checkbox"/> Stents: _____ <input type="checkbox"/> Bypass surgery
<input type="checkbox"/> High cholesterol (Hyperlipidemia)	<input type="checkbox"/> Diet controlled <input type="checkbox"/> Medication	<input type="checkbox"/> Liver Disease (type: _____)	
<input type="checkbox"/> Obstructive Sleep Apnea	<input type="checkbox"/> Using CPAP <input type="checkbox"/> CPAP prescribed, not used <input type="checkbox"/> Using mouth spacer	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Medication <input type="checkbox"/> Dialysis
<input type="checkbox"/> Gastroesophageal Reflux (GERD, heartburn)	<input type="checkbox"/> Diet controlled <input type="checkbox"/> Medication	<input type="checkbox"/> Asthma	<input type="checkbox"/> Medication <input type="checkbox"/> Frequency of inhaler use: _____
<input type="checkbox"/> Arthritis / Joint Pain	<input type="checkbox"/> Physical therapy <input type="checkbox"/> Prior surgery	<input type="checkbox"/> Cancer (Type: _____)	<input type="checkbox"/> Active treatment?
<input type="checkbox"/> Birth defects/Syndromes (type: _____)	<input type="checkbox"/> Active monitoring? <input type="checkbox"/> Medication	<input type="checkbox"/> Suicidality	<input type="checkbox"/> Currently <input type="checkbox"/> Only in past
<input type="checkbox"/> Depression	<input type="checkbox"/> Therapy / counseling <input type="checkbox"/> Medication	<input type="checkbox"/> Irregular Menstrual Cycles (if applicable)	<input type="checkbox"/> Active monitoring? <input type="checkbox"/> Medication
<input type="checkbox"/> Polycystic Ovaries	<input type="checkbox"/> Medication	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Medication <input type="checkbox"/> Prior thyroid surgery
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	

Birth History	Gestational Age at Birth: <input type="checkbox"/> Full Term <input type="checkbox"/> Pre Term (weeks: _____) <input type="checkbox"/> Post Term (weeks: _____)
Birth Weight: _____	Breastfed? <input type="checkbox"/> No <input type="checkbox"/> Yes, how long: _____
Infant complications after during pregnancy or after birth? <input type="checkbox"/> No <input type="checkbox"/> Yes; explain:	
Maternal complications during pregnancy? <input type="checkbox"/> No <input type="checkbox"/> Yes; explain:	



Surgical History		You may not be familiar with some terms, but mark all that apply. Add anything not listed.	
SURGERY TYPE	APPROACH	YEAR	
<input type="checkbox"/> Appendix (appendectomy)	<input type="checkbox"/> Laparoscopic <input type="checkbox"/> Open <input type="checkbox"/> I don't know		
<input type="checkbox"/> Gallbladder (cholecystectomy)	<input type="checkbox"/> Laparoscopic <input type="checkbox"/> Open <input type="checkbox"/> I don't know		
<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Laparoscopic <input type="checkbox"/> I don't know <input type="checkbox"/> Open <input type="checkbox"/> Vaginal		
<input type="checkbox"/> Previous bariatric surgery <i>List type:</i>	<input type="checkbox"/> Laparoscopic <input type="checkbox"/> Open	<i>Hospital:</i>	
<input type="checkbox"/> Other <i>List type:</i>			
<input type="checkbox"/> Other <i>List type:</i>			
<input type="checkbox"/> Other <i>List type:</i>			

Medications		List all current medications or attach up-to-date and current list.		
MEDICATION	DOSE	SCHEDULE	PURPOSE	
Example only: <i>Metformin</i>	<i>500mg</i>	<i>1 pill twice a day</i>	<i>diabetes</i>	



Allergies section: List all medication/food allergies or indicate: [ ] I have no known allergies. Table with columns: MEDICATION NAME, REACTION.

Social History section: Fill out everything to the best of your knowledge. [ ] Check if "NO" for entire section. Sub-sections: TOBACCO USE, ALCOHOL USE, SUBSTANCE USE.

Review of Body Systems section: Mark all symptoms that you are \*\*currently\*\* experiencing. Grid with columns: GENERAL, EYES, EARS / NOSE / THROAT, RESPIRATORY, CARDIOVASCULAR, GASTROINTESTINAL, URINARY, SKIN / BREAST, HEMATOLOGIC, MUSCULOSKELETAL, NEUROLOGICAL, SLEEP.

NAME: \_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_ DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_



<b>Obesity History</b>	1. First considered OVERWEIGHT at was age?	2. Family History of Overweight/Obesity? YES NO If yes, who?
	2. Reason(s) for weight gain?	
	3. How does your weight currently limit you?	
	4. Have you ever been (or are you now) "picked-on" or "bullied" because of your weight?	
	7. What do you see as your 2 biggest barriers to losing weight?	
	8. What are at least 2 benefits of weight loss for you?	

<b>Sleep Assessment</b>	1. How much sleep do you get at night, on average?		
	2. Do you feel rested when you wake up in the morning?		
	3. Has anyone told you that you stop breathing during your sleep?		
	4. How likely are you to fall asleep or doze in the following situations (NOT just feeling tired)? Use the scale below to choose the most appropriate number for each situation: 0 – No chance of dozing 1 – Slight chance of dozing 2 – Moderate chance of dozing 3 – High chance of dozing		
SITUATION	CHANCE OF DOZING	SITUATION	CHANCE OF DOZING
Sitting and reading		Lying down to rest in the afternoon (when able)	
Watching TV		Sitting and talking to someone	
Sitting inactive in a public place (theater or meeting)		Sitting quietly after lunch without alcohol	
As a passenger in a car for 1 hour without a break		In a car, while stopped for a few minutes in traffic	

<b>Activity History</b>	1. Do you have any limitations or injuries that make exercise difficult? Explain.
	2. How many minutes of exercise or "active play" do you engage in per day?
	3. How many minutes of total "screen time" do you have per day (TV, internet, games, etc. Do not include required school activities done on computer)?



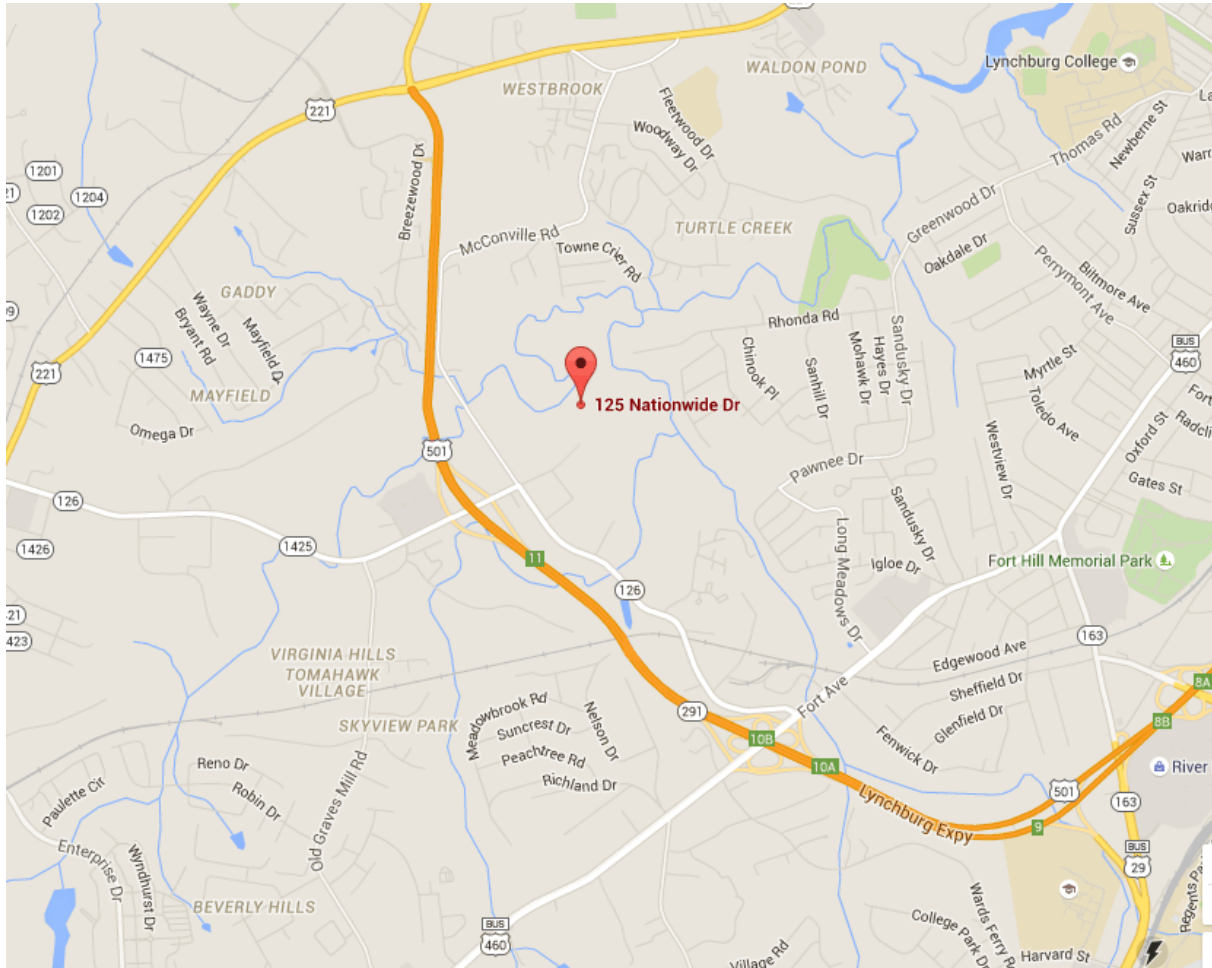
Upon completion, submit this information packet either *in person* or *by mail* to:

**Centra Weight Loss Clinic (Administration)**  
125 Nationwide Drive  
Lynchburg, VA 24501

We want to safeguard your personal information as best we can. Please do not email or fax this packet. We will contact you after receiving your packet.

Clinic appointments will be held at:

**Centra Weight Loss Clinic**  
125 Nationwide Drive  
Lynchburg, VA 24502



You may keep this sheet as a reference.

NAME: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_