new direction
weight control system

Forever Weight Loss

A New Direction

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# Patient Enrollment Packet

# Forever Weight Loss/Enrollment Application
# For The New Direction VLCD and New Direction LCD

CONFIDENTIAL

DATE: _____

NOTE: This form must be completed before you can be enrolled in the New Direction (ND) System. Please answer every question. Please print, type or write clearly.

Name (Last-First-Initial)

| Address (Street-City-State-Zip) | | Daytime Phone No. |
|---|---|---|
| Occupation | Name of Employer | Evening Phone No. |
| Birth date (Month-Day-Year) | Circle Marital Status<br>Single Married Divorced Separated Widowed | SEX (CIRCLE)<br>MALE FEMALE |

Circle Level of Highest Education Completed

Grade School High School Some College College Grad Grad School Some Tech School Tech School Grad

Please give the name and address of a friend or relative with a stable address (for emergency)

| Name (Last-First-Initial) | Address (Street-City-State-Zip) | Phone No. |
|---|---|---|
| | | |

Have you been treated at this health care facility before? ☐ Yes ☐ No

## WEIGHT HISTORY

| | |
|---|---|
| Patient weight (lbs) | Indicate ages during which you were overweight |
| Present height (feet, inches) | ☐ Childhood (Age 2-11 yrs) |
| What is your goal weight? | ☐ Adolescence (Age 12-19 yrs) ☐ Age 20-29 yrs |
| When did you last weight this amount? | ☐ Age 30-40 yrs<br>☐ Over 40 yrs |

How much weight do you expect to lose during this program? _____ lbs.

Which weight loss methods have you tried in the past? Please be as specific as possible (eg. NutriSystem, Jenny Craig, Starvation, Protein Formula, Medications, Spa, Hypnosis, Weight Watchers, Psychotherapy, Etc.)

| Weight loss method | How long was loss maintained? | Why did you stop treatment? | Problems during treatment | Which weight loss method do you consider your most successful? |
|---|---|---|---|---|

| *Sample:*<br>*Stillman Diet* | *2 months* | *Desired other foods* | *Dizziness* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## MEDICAL HISTORY

Physician to receive your progress reports:

Name Office Address Phone

When was your most recent complete physical exam? Month: Year:

Please indicate whether you have ever used or are still using any of the following medications.

| Ever Used | Still Using | Category | Name | Year Started | Dosage |
|---|---|---|---|---|---|
| | | Lithium Carbonate | | | |
| | | Corticosteroids | | | |
| | | Phenothiazines | | | |
| | | Diuretics (Water Pills) | | | |
| | | Beta-Blockers | | | |
| | | Ace Inhibitors | | | |
| | | Calcium Channel Blockers | | | |
| | | Insulin (types) | | | |
| | | Oral Diabetic Agents | | | |
| | | Thyroid Hormones | | | |
| | | Birth Control Pills | | | |
| | | Other Hormones | | | |
| | | Tranquilizers | | | |
| | | Antidepressants | | | |
| | | Vitamin/Mineral Supplement | | | |
| | | Aspirin or Acetaminophen | | | |
| | | Fiber Supplement | | | |
| | | Other | | | |
| | | Other | | | |

| Please check any health condition you have: | ☐ Peptic ulcer disease that is not resolved or under good medical control |
|---|---|
| ☐ Heart attack within last 3 months | ☐ Recent onset of inflammatory bowel disease |
| ☐ Insulin-dependent diabetes (juvenile-onset diabetes) | ☐ Non-insulin dependent diabetes |
| ☐ Liver disease requiring protein restriction | ☐ Other (Explain) |
| ☐ Pregnant or planning to become pregnant within 6 months | |
| ☐ Kidney disease requiring protein restriction | Date of most recent menstrual period _____ |

| | |
|---|---|
| ☐ Recent treatment for cancer (please describe) | Number of pregnancies _____ |
| ☐ Recent uric acid kidney stone or untreated hyperuricemia | Weight gain with pregnancies _____ lbs |

## PSYCHOSOCIAL HISTORY

Are you at present undergoing any major lifestyle changes (eg, marriage, divorce, job change, death of someone important to you)? If so, describe:

What other commitments do you that might interfere with your fully participating in the New Direction System?

What benefits do you hope to gain from being in this program other than losing weight?

Who do you feel will be supportive of your weight loss and changes in lifestyle? (circle and name your choices)
Spouse Children Roommate(s) Parent(s) Friend(s) Co-worker(s) Other

Who do you feel may **not** be supportive of your weight loss and changes in lifestyle? (circle and name your choices)
Spouse Children Roommate(s) Parent(s) Friend(s) Co-worker(s) Other

## PSYCHOSOCIAL HISTORY (CONT.)

List five reasons you think it is important for you to lose weight. Please number the reasons, with "1" being the most important.

1.

2.

3.

4.

5.

Why did you choose this particular program?

Are you currently in any kind of psychotherapy? If yes, please specify: ☐ YES ☐ NO

| With whom | For what | Date treatment began |
|---|---|---|
| | | |

Have you been in any kind of psychotherapy in the past? If yes, please specify: ☐ Yes ☐ No

| With whom | For what | Date treatment began | Ending date |
|---|---|---|---|
| | | | |

Have you ever been hospitalized for psychiatric reasons? If so, please complete the following:

| Date of Admission | Length of Stay | Reason for Hospitalization |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

| Have you ever had suicidal thoughts? | Have you ever been severely depressed? | Have you ever experienced dramatic mood changes during dieting (especially anxiety or depression)? |
|---|---|---|
| ☐ Yes ☐ No | ☐ Yes ☐ No ☐ Possibly | ☐ Yes ☐ No ☐ Possibly |

Have you ever eaten a large amount of food rapidly and felt this eating incident was excessive and out of control (aside from holiday feasts)? ☐ Yes ☐ No If yes, how often did you do this during the past year? (check one)

☐ Less than once a month
☐ About once a month
☐ A few times a month
☐ About once a week
☐ About three times a week
☐ Daily

Have you ever purged (used self-induced vomiting, laxatives, or diuretics)? ☐ Yes ☐ No

## LIFESTYLE AND EATING HABITS

Do you drink alcohol? ☐ Yes ☐ No

If yes, how much?
- ☐ 1 drink a month
- ☐ 1 drink a week
- ☐ More than 1 drink a week
- ☐ 1 drink a day
- ☐ More than 1 drink a day

How often do you exercise?
- ☐ Rarely
- ☐ Occasionally
- ☐ 1-2 times a week
- ☐ 3-4 times a week
- ☐ 5 or more times a week

Has any doctor or other health care professional ever told you not to exercise? ☐ Yes ☐ No

Do you know of any reason why you should not exercise? ☐ Yes ☐ No

If you answered yes to either question, please explain:

_____ _____ _____

_____ _____ _____

_____ _____ _____

How many meals do you typically eat out per week? _____

Are the majority of these meals with family or friends? ☐ Yes ☐ No

Are they usually fast food (eg, McDonald's)? ☐ Yes ☐ No

Usually in cafeteria/restaurant? ☐ Yes ☐ No

## LIFESTYLE AND EATING HABITS (CONT.)

Of the following, check all the items that you feel help explain or describe your eating habits:

- ☐ Thinking about food too much of the time
- ☐ Eating high-fat foods
- ☐ Eating too many sweet foods
- ☐ Eating too quickly
- ☐ Uncontrollable binges
- ☐ Eating in reaction to tension and depression
- ☐ Eating to take my mind off other problems
- ☐ Not paying attention to what I'm eating
- ☐ Overeating at social events
- ☐ Lack of satisfaction in life
- ☐ Eating in reaction to boredom
- ☐ Other (explain) _____
- ☐ Overeating when alone
- ☐ Using food as a reward

_____ _____

_____ _____

Are you allergic to

| | | |
|---|---|---|
| Cocoa? | ☐ Yes | ☐ No |
| Milk protein? | ☐ Yes | ☐ No |
| Corn? | ☐ Yes | ☐ No |
| Soy? | ☐ Yes | ☐ No |
| Eggs? | ☐ Yes | ☐ No |

Other food? (describe) _____

Are you sensitive to or do you have a problem with

| | | |
|---|---|---|
| Aspartame (Nutrasweet)? | ☐ Yes | ☐ No |
| Monosodium glutamate (MSG)? | ☐ Yes | ☐ No |
| Lactose? (unable to drink milk but able to eat cheese and yogurt) | ☐ Yes | ☐ No |

Do you smoke? ☐ Yes ☐ No

I certify that the information on this form is true and correct to the best of my knowledge.

_____ _____

Signature Date

I give permission for the data provided in this from and obtained in subsequent visits and interviews to be submitted to Robard Corporation, Division of Food Sciences, for the purpose of group evaluation of data. Except for the purpose of matching current and future data, my name will not be used in conjunction with any of the data. I understand that such group evaluation may, from time to time, be used in publications or other materials, but that participant confidentiality will be maintained.

_____ _____

Signature Date

# Patient Information

Patient Name:_____
Address:_____
_____
PhoneNumber:_____
EmailAddress:_____
Emergency Contact:_____

Have you ever had weight loss surgery? _____
If so, when and by whom?_____

new direction weight control system

## Diet Readiness Behavioral Questionnaire

For each question, circle the answer that best describes how you feel.

### Section 1: Goals and Attitudes

1. Compared to previous attempts, how motivated to lose weight are you this time?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Not At All Motivated | Slightly Motivated | Somewhat Motivated | Quite Motivated | Extremely Motivated |

2. How certain are you that you will stay committed to a weight loss program for the time it will take to reach your goal?

| 1 | 2 | 3 | 4 | |
|---|---|---|---|---|
| Not At All | Slightly | Somewhat | Quite | Extremely Certain |

3. Consider all outside factors at this time in your life (the stress you're feeling at work, your family obligations, etc). To what extent can you tolerate the effort required to stick to a diet?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Cannot Tolerate | Can Tolerate Somewhat | Uncertain | Can Tolerate Well | Can Tolerate Easily |

4. Think honestly about how much weight you hope to lose and how quickly you hope to lose it. Figuring a weight loss of 1 to 2 pounds per week, how realistic is your expectation?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Very Unrealistic | Somewhat Unrealistic | Moderately Unrealistic | Somewhat Realistic | Very Realistic |

5. While dieting, do you fantasize about eating a lot of your favorite foods?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Always | Frequently | Occasionally | Rarely | Never |

6. While dieting, do you feel deprived, angry and/or upset?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Always | Frequently | Occasionally | Rarely | Never |

***Section 1 TOTAL SCORE***

## Section 2: Hunger and Eating Cues

7. When food comes up in conversation or in something you read, do you want to eat even if you are not hungry?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never | Rarely | Occasionally | Frequently | Always |

8. How often do you eat because of physical hunger?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Always | Frequently | Occasionally | Rarely | Never |

9. Do you have trouble controlling your eating when your favorite foods are around the house?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never | Rarely | Occasionally | Frequently | Always |

***Section 2 TOTAL SCORE***

## Section 3: Control Over Eating

If the following situations occurred while you were on a diet, would you be likely to eat **more** or **less** immediately afterward and for the rest of the day?

10. Although you planned on skipping lunch, a friend talks you into going out for a midday meal.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Would Eat Much Less | Would Eat Somewhat Less | Would Make No Difference | Would Eat Somewhat More | Would Eat Much More |

11. You "break" your diet by eating a fattening, "forbidden" food.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Would Eat Much Less | Would Eat Somewhat Less | Would Make No Difference | Would Eat Somewhat More | Would Eat Much More |

12. You have been following your diet faithfully and decide to test yourself by eating something you consider a treat.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Would Eat Much Less | Would Eat Somewhat Less | Would Make No Difference | Would Eat Somewhat More | Would Eat Much More |

***Section 3 TOTAL SCORE*** _____

## Section 4: Binge Eating and Purging

13. Aside from holiday feasts, have you ever eaten a large amount of food rapidly and felt afterward that this eating incident was excessive and out of control?

| 2 | 0 |
|---|---|
| Yes | No |

14. If you answered yes to #13, how often have you engaged in this behavior during the last year?

| 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|
| Less Than Once A Month | About Once A Month | A Few Times A Month | About Once A Week | About Three Times A Week | Daily |

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

| 5 | 0 |
|---|---|
| Yes | No |

16. If you answered yes to #15 above, how often have you engaged in this behavior during the last year?

| 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|
| Less Than Once A Month | About Once A Month | A Few Times A Month | About Once A Week | About Three Times A Week | Daily |

***Section 4 TOTAL SCORE*** _____

## Section 5: Emotional Eating

17. Do you eat more than you would like to when you have negative feelings such as anxiety, depression, anger or loneliness?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never | Rarely | Occasionally | Frequently | Always |

18. Do you have trouble controlling your eating when you have positive feelings - do you celebrate feeling good by eating

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never | Rarely | Occasionally | Frequently | Always |

19. When you have unpleasant interactions with others in your life, or after a difficult day at work, do you eat more than you'd like?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never | Rarely | Occasionally | Frequently | Always |

***Section 5 TOTAL SCORE***

## Section 6: Exercise Patterns and Attitudes

20. How often do you exercise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never | Rarely | Occasionally | Somewhat | Frequently |

21. How confident are you that you can exercise regularly?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Not At All Confident | Slightly Confident | Somewhat Confident | Highly Confident | Completely Confident |

22. When you think about exercise, do you develop a positive or negative picture in your mind?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Completely Negative | Somewhat Negative | Neutral | Somewhat Positive | Completely Positive |

23. How certain are you that you can work regular exercise into your daily schedule?

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Not At All | Slightly Somewhat | Quite Extremely | Certain |

***Section 6 TOTAL SCORE***