

# **Allina Health Weight Management**

Thank you for choosing Allina Health Weight Management. The Weight Management Program offers comprehensive weight loss options for patients of all ages. Please review the following descriptions to assure we get you scheduled with the right program and providers.

## **Kids and Teens Weight Management Program**

The Kids and Teens program is a resource for kids, teens, and young adults to achieve a healthier weight. Through the program families and patients work with medical doctors, dietitians, nurse practitioners, mental health providers, physical therapists, surgeons, and other specialists. If you are interested in the Kids and Teens Weight Management Program, please complete the intake form for that program. It can be found at [AllinaHealth.org/kidswm](http://AllinaHealth.org/kidswm).

## **Medical Weight Management Program**

**Individual Program** – The individual program is a personalized, one-on-one non-surgical program. Patients meet with a weight loss physician or nurse practitioner to create a specialized treatment plan. A registered dietitian will develop a diet tailored to your specific needs. The focus is on portion control, healthy eating, and a moderately reduced calorie diet that will work for you. This plan may include medications. The individual program cost for provider and dietitian visits is covered by most insurers, with the exception of Medicare and Medicare replacement plans.

**Group Program** – The group program is a medically supervised, non-surgical weight loss program. Groups start 4 times per year (January, April, July, and October). The group program is covered by most insurers, including Medicare and Medicaid. Groups include: one-on-one medical evaluation by a nurse practitioner, information about nutrition, physical activity, and emotional well-being, as well as support and guidance to make incremental changes in your life.

## **Optifast Meal Replacement Program**

The Optifast program is a medically supervised complete meal replacement program. Patients are seen by a nurse practitioner or physician assistant during the active weight loss phase. Lifestyle and behavior change are key to success. The Optifast program includes weekly classes and visits with our registered dietitian. The weekly classes are taught by healthcare professionals (Registered Dietitian, Exercise Physiologist, Nurse Practitioner and Physician Assistant). Classes are 45 to 60 minutes in length and are not mandatory, but are highly encouraged as those who attend group sessions for weight management lose more weight. If you are interested in the Optifast program, please complete the intake form for that program. The Optifast Health History Form can be found at [allinahealth.org/mwm](http://allinahealth.org/mwm) at the bottom of the webpage.

## **Surgical Weight Management Program**

The surgical program offers the sleeve gastrectomy, Roux-en-Y gastric bypass, and duodenal switch operations. Your decision to have weight loss surgery is personal and complex. The Surgical Weight Management team of surgeons, physician assistants, nurse practitioners, psychologists, nurses, dietitians, and support staff will provide support, assistance, and advice throughout your journey before and after weight loss surgery.

**Please remember that with any clinic visit, co-pays,  
coinsurance and deductibles may apply.**

## **Intra-gastric Balloon Program**

The intra-gastric balloon is a non-surgical procedure. Two connected balloons are placed inside your stomach for six months to help reduce hunger. No hospital stay is required – you go home the same day. The Weight Management team of surgeon, nurse and dietitian provide guidance, education, and motivation for the support you need to create permanent lifestyle changes. This is a self-pay procedure, not covered by insurance.

Office Use Only:

Date Rcvd: \_\_\_\_\_

MRN: \_\_\_\_\_

Approval: \_\_\_\_\_

EE: \_\_\_\_\_

Appts: \_\_\_\_\_

Excellian: \_\_\_\_\_

Ins: \_\_\_\_\_

Stop Bang \_\_\_\_\_

Doc Type: Questionnaire  
Descriptor: Bariatric

## Allina Health Weight Management Health History Form

**Please complete form using blue or black ink**

Indicate which Weight Management Program you would like to enroll in. Refer to cover letter on page 1 for a description of the programs. **Select only one option.**

### Kids & Teens Program

Please use separate health history form located at [allinahealth.org/kidswm](http://allinahealth.org/kidswm) or call 763-236-0940 for a copy.

**Optifast Medical Program: this is the Optifast Meal Replacement Program that includes food products for purchase.**

- ☐ Hopkins
- ☐ Vadnais Heights
- ☐ Woodbury

**Medical Program: this is the non-surgical program that may include medications**

- ☐ Abbott Northwestern
- ☐ Fridley
- ☐ Hopkins
- ☐ United

**Medical Program Group: this is the 12 week non-surgical group program**

- ☐ Hopkins

**Surgical Program: this is for weight loss surgery**

- ☐ Abbott Northwestern
- ☐ Mercy
- ☐ St. Francis
- ☐ United

**Intra-gastric Balloon Program: this is a self-pay procedure**

- ☐ Abbott Northwestern
- ☐ St. Francis

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

### **Weight History**

What is your current height?	What is your current weight?
BMI (this will be calculated by staff)	
How long have you been this weight?	Years:
At what age did you first become overweight?	
Lowest adult weight	Highest adult weight (non-pregnant)
Average weight over the past 5 years	



### Allina Health Weight Management Program Health History Form



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PATIENT LABEL

Patient Name:

\_\_\_\_\_

Patient Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Medical History**

Cardiovascular	Respiratory	Musculoskeletal	Endocrine
<input type="checkbox"/> irregular heart beat	<input type="checkbox"/> asthma	<input type="checkbox"/> osteoarthritis	<input type="checkbox"/> diabetes type I
<input type="checkbox"/> heart block	<input type="checkbox"/> obstructive sleep apnea	<input type="checkbox"/> rheumatoid arthritis	<input type="checkbox"/> diabetes type II
<input type="checkbox"/> pacemaker/palpitations	<input type="checkbox"/> pulmonary hypertension	<input type="checkbox"/> degenerative disc disease (DDD)	<input type="checkbox"/> glucose intolerance / pre-diabetic
<input type="checkbox"/> chest pain (angina)	<input type="checkbox"/> emphysema/COPD	<input type="checkbox"/> degenerative joint disease (DJD) where: _____	<input type="checkbox"/> diabetic eye problems
<input type="checkbox"/> heart disease	<input type="checkbox"/> pulmonary embolism	<input type="checkbox"/> herniated disc	<input type="checkbox"/> diabetic ulcers
<input type="checkbox"/> congestive heart failure	<b>Liver/Stomach/Intestine</b>	<input type="checkbox"/> gout	<input type="checkbox"/> low thyroid (hypothyroid)
<input type="checkbox"/> heart attack (MI)	<input type="checkbox"/> gallstones	<input type="checkbox"/> carpal tunnel syndrome	<input type="checkbox"/> infertility
<input type="checkbox"/> high blood pressure	<input type="checkbox"/> inflamed gallbladder	<input type="checkbox"/> plantar fasciitis	<input type="checkbox"/> hypoglycemia
<input type="checkbox"/> coronary artery disease	<input type="checkbox"/> hepatitis	<input type="checkbox"/> joint pain	<input type="checkbox"/> metabolic syndrome
<input type="checkbox"/> carotid artery disease	<input type="checkbox"/> ulcer	<input type="checkbox"/> swelling	<input type="checkbox"/> morbid obesity
<input type="checkbox"/> edema	<input type="checkbox"/> h. pylori	<input type="checkbox"/> pain	<input type="checkbox"/> obesity
<input type="checkbox"/> high triglycerides	<input type="checkbox"/> colitis	<input type="checkbox"/> stiffness	<input type="checkbox"/> pancreatitis
<input type="checkbox"/> high cholesterol or low HDL	<input type="checkbox"/> spastic colon	<b>Neurological</b>	<b>Reproductive/Male</b>
<input type="checkbox"/> heart murmur / abnormal heart valve	<input type="checkbox"/> irritable bowel	<input type="checkbox"/> seizures	<input type="checkbox"/> prostate cancer
<input type="checkbox"/> pass out or lose consciousness	<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> migraines	<input type="checkbox"/> impotence
<input type="checkbox"/> blood clot or DVT	<input type="checkbox"/> acid reflux or heartburn	<input type="checkbox"/> neuropathy/nerve pain	<input type="checkbox"/> penile deformity
<input type="checkbox"/> renal insufficiency	<input type="checkbox"/> fatty liver (NASH or NAFLD)	<input type="checkbox"/> sciatica	<input type="checkbox"/> penile prosthetic device
<input type="checkbox"/> diabetic kidney disease	<input type="checkbox"/> increased LFT's	<input type="checkbox"/> pseudo tumor cerebri	<input type="checkbox"/> enlarged prostate
<input type="checkbox"/> kidney failure	<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> narcolepsy/ drop attacks	<input type="checkbox"/> urinary symptoms due to enlarged prostate
<input type="checkbox"/> currently on dialysis	<input type="checkbox"/> pancreatitis	<input type="checkbox"/> paralysis	<b>Other</b>
<input type="checkbox"/> stress incontinence	<input type="checkbox"/> trouble swallowing	<input type="checkbox"/> restless legs	<input type="checkbox"/> awaiting organ transplant – type: _____
<input type="checkbox"/> kidney stones	<b>Infectious Diseases</b>	<input type="checkbox"/> fibromyalgia	<input type="checkbox"/> glaucoma: open angle
<input type="checkbox"/> problems with healing of wounds/cuts/bruises	<input type="checkbox"/> VRE	<input type="checkbox"/> multiple sclerosis	<input type="checkbox"/> glaucoma: narrow angle
	<input type="checkbox"/> MDRO	<input type="checkbox"/> stroke/CVA	<input type="checkbox"/> glaucoma: unknown
	<input type="checkbox"/> MRSA	<input type="checkbox"/> Charcot Marie Tooth Syndrome	<input type="checkbox"/> other eye problem
	<input type="checkbox"/> C Diff		<input type="checkbox"/> history of cancer
	<input type="checkbox"/> HIV positive		



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PATIENT LABEL

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Review of Systems

Check off any symptoms you **currently** have:

General	Cardiac	Musculoskeletal	Male Genital/Urinary
<input type="checkbox"/> fatigue	<input type="checkbox"/> chest pain	<input type="checkbox"/> low back pain	<input type="checkbox"/> incontinence
<input type="checkbox"/> fevers	<input type="checkbox"/> fast heart rate	<input type="checkbox"/> neck pain	<input type="checkbox"/> blood in urine
<input type="checkbox"/> chills	<input type="checkbox"/> irregular heart rate	<input type="checkbox"/> muscle pain	<input type="checkbox"/> difficult urination
<input type="checkbox"/> insomnia	<input type="checkbox"/> lightheadedness	<input type="checkbox"/> fibromyalgia	<input type="checkbox"/> up at night to urinate
<input type="checkbox"/> excessive daytime sleepiness or drowsiness	<input type="checkbox"/> fainting or passing out	<input type="checkbox"/> joint pain – location:	<input type="checkbox"/> impotence
	<input type="checkbox"/> none of the above		<input type="checkbox"/> erectile dysfunction
<input type="checkbox"/> none of the above	Gastrointestinal	<input type="checkbox"/> muscle or joint stiffness	<input type="checkbox"/> none of the above
Head and Neck	<input type="checkbox"/> heartburn	<input type="checkbox"/> mobility problems	Female Genital/Urinary
<input type="checkbox"/> TMJ	<input type="checkbox"/> constipation	<input type="checkbox"/> use of cane or walker	<input type="checkbox"/> stress incontinence
<input type="checkbox"/> recent dental problems	<input type="checkbox"/> diarrhea	<input type="checkbox"/> none of the above	<input type="checkbox"/> menstrual irregularity
<input type="checkbox"/> none of the above	<input type="checkbox"/> IBS	Skin	<input type="checkbox"/> heavy menses
Eyes	<input type="checkbox"/> lactose intolerance	<input type="checkbox"/> acne	<input type="checkbox"/> blood in urine
<input type="checkbox"/> change in vision	<input type="checkbox"/> wheat intolerance	<input type="checkbox"/> recurrent skin infections	<input type="checkbox"/> excessive facial hair
<input type="checkbox"/> eye pain	<input type="checkbox"/> hemorrhoids	<input type="checkbox"/> skin tags	<input type="checkbox"/> none of the above
<input type="checkbox"/> none of the above	<input type="checkbox"/> stool incontinence	<input type="checkbox"/> stretch marks	Neurological
Respiratory	<input type="checkbox"/> abdominal pain	<input type="checkbox"/> none of the above	<input type="checkbox"/> seizures
<input type="checkbox"/> shortness of breath at rest	<input type="checkbox"/> Nausea/vomiting	Vascular	<input type="checkbox"/> tremors
<input type="checkbox"/> shortness of breath with activity	<input type="checkbox"/> none of the above	<input type="checkbox"/> swelling of lower extremities	<input type="checkbox"/> headaches
	Psychological		<input type="checkbox"/> migraines
<input type="checkbox"/> cough	<input type="checkbox"/> excessive worry	<input type="checkbox"/> ulcers of lower extremities	<input type="checkbox"/> tension headaches
<input type="checkbox"/> snoring	<input type="checkbox"/> anxiety		<input type="checkbox"/> balance problems
<input type="checkbox"/> waking up due to snoring or stopping breathing	<input type="checkbox"/> panic attacks	<input type="checkbox"/> none of the above	<input type="checkbox"/> walking problems
	<input type="checkbox"/> depression		<input type="checkbox"/> nerve pain
<input type="checkbox"/> none of the above	<input type="checkbox"/> feeling “up” or elated		<input type="checkbox"/> numbness/tingling
	<input type="checkbox"/> none of the above		<input type="checkbox"/> none of the above

STOP BANG

**If you have already been diagnosed with sleep apnea and have been prescribed a CPAP or BiPAP, you do NOT have to complete this section.**

Collar size of shirt   ☐ S   ☐ M   ☐ L   ☐ XL   or \_\_\_\_\_ inches cm  
 Neck circumference \_\_\_\_\_ inches / cm (This will be measured by staff)

	Yes	No
<i>Snoring</i> – Do you snore loudly (louder than talking or loud enough to be heard through closed doors?)		
<i>Tired</i> – Do you often feel tired, fatigued, or sleepy during the day?		
<i>Observed</i> – Has anyone observed you stop breathing during your sleep?		
<i>Blood Pressure</i> – Do you have or are you being treated for high blood pressure?		
<i>BMI</i> – BMI more than 35 kg/m <sup>2</sup> ?		
<i>Age</i> – Age over 50 years old?		
<i>Neck circumference</i> – Neck circumference greater than 40 cm / 15.75 inches?		
<i>Gender</i> – Gender male?		

**Surgical History**

List all previous surgeries

Surgery	Year	Incision location	Reason

	Yes	No	Comment
Have you had problems with anesthesia?			

Weight Loss Surgery – complete this section **ONLY** if you have had weight loss surgery before

	Comments
What year did you have weight loss surgery?	
Name of surgeon	Where:
Weight before surgery	Lowest weight after surgery
Any adverse events after surgery?	Describe:

Indicate which operation you had

<input type="checkbox"/> gastric bypass (Roux-en-Y)	<input type="checkbox"/> adjustable gastric band (Lap-band or Realize band)
<input type="checkbox"/> duodenal switch	<input type="checkbox"/> vertical banded gastroplasty (VBG)
<input type="checkbox"/> sleeve gastrectomy	<input type="checkbox"/> Other:

Family History

	Age now or at death	Cause of death	Cancer – Colon	Coronary Artery Disease – type and age of onset	Diabetes	High cholesterol	High blood pressure	Obesity	Bleeding or Clotting Disorder	Stroke
Mother										
Father										
Sister										
Brother										
Maternal GrandMa										
Maternal GrandPa										
Paternal GrandMa										
Paternal GrandPa										

Is there a family history of:	Yes	No	Family member
Substance Abuse Dependence			
Depression			
Anxiety			
Severe mental illness			



PATIENT LABEL

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Substance Use**

	Yes	No	Type/Amount/Frequency
Do you currently use tobacco?			
Have you ever used tobacco?			
How many years did you use?			
How much did you use?	Packs per day:		
When did you quit?			
	Yes	No	Type/Amount/Frequency
Do you consume alcohol?			
Last consumed alcohol?	When:		
	Yes	No	Type/Amount/Frequency
Have you ever used an illicit drug such as marijuana, cocaine, meth, or heroin?			
Last use?	When:		
	Yes	No	Type/Amount/Frequency
History of chemical dependency?			
History of chemical dependency treatment?	When:		

**Social History**

	Yes	No	Comment
Are you presently in a relationship?			If yes, for how long?
Do you have children?			What are their ages?
Are you currently employed?			If yes, how long have you been employed? Occupation:
Are you disabled?			Reason: Work status:
Are you sexually active?			If so, male or female partner?
Do you use birth control?			What method?

**Female Reproductive**

	Yes	No	Comment
Is there a <b>possibility that you are pregnant?</b>			
Are you planning future pregnancies?			
Are you <b>currently breast feeding?</b>			
Have you gone through menopause?			
Do you have a history of polycystic ovarian syndrome (PCOS)?			

Menstrual periods – check all that apply

<input type="checkbox"/> Regular	<input type="checkbox"/> Irregular	<input type="checkbox"/> Heavy flow/many clots
<input type="checkbox"/> Normal flow	<input type="checkbox"/> Peri-menopausal	<input type="checkbox"/> Not applicable
What is the date that your last pregnancy was complete / date of delivery?		Date:

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Patient Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Allergies**

List allergies to medicine, food, dye, tape, metal, latex.

Allergy	Reaction

**Medications**

List **all current** medications you are taking including vitamins, over-the-counter medications, supplements, and intermittently used medications.

Name	Dose	How often taken	Purpose	Year started

Pharmacy of Choice – name the pharmacy you use to have your prescriptions filled.

Name of pharmacy	City/Location	Phone Number

**Physical Activity**

Indicate **past** exercise efforts:

<input type="checkbox"/> group exercise classes	<input type="checkbox"/> health club membership (YMCA, Curves, SNAP Fitness, etc.)
<input type="checkbox"/> use of a pedometer	<input type="checkbox"/> home exercise (videos, treadmill, etc.)
<input type="checkbox"/> personal trainer	<input type="checkbox"/> other – describe:

Describe **current** exercise program:

Type of exercise	
Frequency (number of days per week)	
Duration (number of minutes per session)	
If <b>not</b> exercising, what keeps you from exercising?	

Ability to Walk:

<input type="checkbox"/> no limitations	<input type="checkbox"/> Use of a brace	<input type="checkbox"/> Use of a cane	<input type="checkbox"/> Use of a walker	<input type="checkbox"/> Use of a Wheelchair
Are you able to walk 2 blocks?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you able to go up and down a flight of stairs?			<input type="checkbox"/> Yes	<input type="checkbox"/> No

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PATIENT LABEL

Patient Name:

Patient Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_



Have you ever been diagnosed with:

	Yes	No	Date of diagnosis	Treatment
Depression				
Bipolar				
Anxiety / Panic attacks				
Schizophrenia				
Psychosis				
Personality disorder				
Compulsive overeating				
Anorexia Nervosa				
Binge eating disorder				
Bulimia				
Other / describe				

Check all that apply:

	Yes	No	Comment
Thoughts of self harm			
Past suicide attempt			
Under the care of a psychiatrist			
Under the care of a counselor or therapist			

Have you ever been prescribed:

	Yes	No	Date stopped
MAO inhibitor			
tranylcypromine (Parnate)			
phenelzine (Nardil)			
selegiline (Eldepryl, Emsam, Zelapar)			

**Weight Loss History**

Weight Loss Attempts – Indicate which diet programs you have tried in the past

Diet Program	Dates	Pounds lost
Atkins diet		
Cabbage soup		
Calorie counting		
Diabetic diet		
Exercise		
Grapefruit		
Jenny Craig		
LA Weight Loss		
Low fat / low cholesterol		
MD supervised program		
Medifast		
New Day		
Nutrisystem		
Other high protein / low carbohydrate		
Optifast		
Overeaters Anonymous		
Own reduced calorie / portions		
Registered Dietitian visits		
Slimfast		
Slimgenics		
South Beach		
TOPS		
Weight Watchers		
Zone		
Other		

**Do you have a pattern or known causes of weight gain?**

- ☐ Gradual over time
- ☐ Postpartum
- ☐ Depression or other significant life event Describe: \_\_\_\_\_
- ☐ Medication related. Name of medication: \_\_\_\_\_
- ☐ Sudden / unexpected Explain: \_\_\_\_\_
- ☐ Other: \_\_\_\_\_

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PATIENT LABEL

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Weight Loss Medications – Indicate which medications you have used to lose weight

Medication	Dates	Pounds lost
lorcaserin (Belviq)		
metformin (Glucophage)		
naltrexone HCL/Bupropion HCL (Contrave)		
orlistat (Alli, Xenical)		
phentermine		
phentermine / topiramate(Qsymia)		
sibutramine (Meridia)		
topiramate (Topamax or Trolandi)		
wellbutrin		
Other		
Fen-phen		
Redux (dexfenfluramine)		
	Yes	No
Did you take Fen-phen or Redux for longer than 3 months?		
If yes, did you have an echocardiogram?		
	Yes	No
Have you tried diet and exercise for a period of at least 3 months?		
Have you tried diet and exercise for a period of at least 6 months?		
Did you lose 1 pound or more a week while trying diet and exercise?		

Dietary Assessment

What time do you:	Dietary recall:
Wake up?	How many meals do you eat each day?
Eat breakfast?	How many times do you snack each day?
Eat lunch?	How many cups of fruit do you eat each day?
Eat dinner?	How many cups of vegetables do you eat each day? Do not include corn and potatoes
Eat snacks?	
Go to bed?	

Describe what you typically eat for each of the following:

Breakfast	
Lunch	
Dinner	
Snacks	

Dining Out History:

How many times do you eat out each week?	
Where do you dine out?	
What foods do you order when you dine out?	

Describe what you typically consume for liquids:

	Type	Amount in ounces	per day	per week	per month
Alcohol					
Diet soda					
Regular soda					
Milk					
Juice					
Water					
Artificially sweetened water					
Other					
Coffee	<input type="checkbox"/> caffeine <input type="checkbox"/> decaf				
Sugar	How much:				
Cream	How much:				
Tea	<input type="checkbox"/> caffeine <input type="checkbox"/> decaf				
Sugar	How much:				
Cream	How much:				

Meal Activity:

How long does it take you to eat a meal?	
How often do you skip meals?	
Who does the grocery shopping?	
Who prepares the meals in your home?	
Describe your family dynamics around food (as a child and currently)	

	Yes	No	Comment
Do you do any binge eating?			
Do you eat until uncomfortably full?			How often?
Do you eat when not physically hungry?			
Do you worry that you have loss of control over how much you eat?			
Do you wake at night to eat?			

## Global Health

Please respond to each question or statement by marking one box per row.

		Excellent	Very Good	Good	Fair	Poor						
Global01	In general, would you say your health is: .....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1						
Global02	In general, would you say your quality of life is: .....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1						
Global03	In general, how would you rate your physical health? .....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1						
Global04	In general, how would you rate your mental health, including your mood and your ability to think? .....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1						
Global05	In general, how would you rate your satisfaction with your social activities and relationships? .....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1						
Global09	In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.) .....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1						
Global06	To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair? .....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1						
	<b>In the past 7 days...</b>	<b>Never</b>	<b>Rarely</b>	<b>Sometimes</b>	<b>Often</b>	<b>Always</b>						
Global10	How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable? .....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1						
Global08	How would you rate your fatigue on average? .....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1						
Global07	How would you rate your pain on average? .....	<input type="checkbox"/> 0 No pain	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10 Worst pain imaginable

### ***Medical Care Providers***

List all providers you receive care from, starting with your primary care provider. Include their area of specialty, addresses, and phone numbers.

Primary Care Provider: \_\_\_\_\_ Clinic: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Provider Name: \_\_\_\_\_ Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

Mental Health Provider Name: \_\_\_\_\_ Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

### Appointment Policy

We try to provide the best service possible to the clients we serve. To allow us to do this, it is important that you come for all of your scheduled appointments. If you need to cancel or reschedule, please contact our office at least 24 hours in advance. This allows us the opportunity to offer that appointment time to another patient who is waiting.

If you have three cancellations without 24 hours' notice or three no shows in one year, program services may be terminated. The Program Manager or Nurse Clinician will attempt to contact you to assess your ongoing interest and commitment to the program.

If you need to cancel or reschedule an appointment please contact the clinic where your appointment is scheduled.



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PATIENT LABEL

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

# SURGICAL PROGRAM INSURANCE VERIFICATION FORM

Only complete this form if you are interested in weight loss surgery.

**Medicare Patients:** Be aware that Medicare and Medicare replacement plans do not cover dietitian visits. Medicare enrollees may be asked to sign a waiver acknowledging these visits may not be a covered service. The cost for the dietitian component of the program will be at least \$620.00

Patient Initials \_\_\_\_\_

You must contact your insurance company to determine your coverage for weight loss services. To do so, please call the customer service number on the back of your insurance card. Keep record of the date of your call as well as the name of the customer service representative who provided you the information.

If you are enrolling in the Surgical Program, we will contact your insurance carrier as well to verify your coverage and criteria for weight loss surgery. This is to ensure that all information provided to *you* and to *us* is accurate. In order to do this on your behalf, please complete the following:

Your Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you had weight loss surgery in the past? ☐ Yes ☐ No

## INSURANCE INFORMATION

Primary Insurance:

Company: \_\_\_\_\_/ID# \_\_\_\_\_ Group# \_\_\_\_\_

Secondary Insurance (If applicable):

Company: \_\_\_\_\_/ID# \_\_\_\_\_ Group# \_\_\_\_\_

If UCARE Insurance, what is the PMI number: \_\_\_\_\_

Are you the subscriber: ☐ Yes ☐ No

If not, Name of Subscriber, Date of Birth, and Relationship

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Social Security Number of Subscriber: \_\_\_\_\_ (Tricare and Veterans Insurance ONLY)

Provider Phone Number OR Customer Service Phone Number on the back of your insurance card: \_\_\_\_\_

We will document the information we receive in your Excellian Chart. This will be provided to your nurse clinician prior to your Initial Visit so that she can accurately determine a plan of care for you to meet your specific insurance criteria. If we determine that you **DO NOT have insurance coverage for weight loss surgery**, we will contact you. Please provide the best phone number to reach you and also indicate if we are able to leave a message for you at that phone number.

Phone: \_\_\_\_\_ Okay to Leave a Message: ☐ Yes ☐ No

For Office Use Only:

Location: ANW HOP MCY STF UTD

Provider: \_\_\_\_\_

Date of Visit: \_\_\_\_\_



Allina Health Weight Management  
Program Health History Form



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PATIENT LABEL

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_