

Greetings!

Thank you for your interest in the Comprehensive Weight Management Program. We commend you for taking an active role to improve your health! You are about to embark on one of the most positive journeys of your life, not to mention an incredible learning experience.

Please complete the enclosed enrollment and registration packets. In order for us to properly assess your specific needs and desires, it is important to be completely honest when completing the questionnaires. If you have trouble answering or are confused by any questions, please indicate so and answer the question to the best of your ability.

You will be scheduled for an assessment intake appointment with a Registered Dietitian, Behavioral Health Specialist and an Exercise Physiologist upon receipt of the following:

- Completed registration and enrollment forms (pages 2-5)
- Prior authorization and referral form (filled out and signed by your primary care provider)
- Pre-authorization letter from your insurance company

Enclosed is a self-addressed envelope in which to return the enclosed forms. If you printed this packet from the Internet, our mailing address is:

Healthy Weight Center  
Munson Medical Center  
1105 Sixth Street  
Traverse City, MI 49684

Should you need to cancel or reschedule any appointment, 24-hours notice is required.

If you have any questions or concerns regarding the program, please feel free to call. We look forward to working with you.

Sarah Wetmore, M.A., CES  
Coordinator  
Healthy Weight Center  
(231) 935-8533 (phone)  
(231) 935-8609 (fax)

# MUNSON MEDICAL CENTER

## Healthy Weight Center

### Registration Form

In order for us to process your registration form quickly and accurately, please print legibly and be sure to complete the entire form. If you have questions please ask for assistance.

(circle one)

Mr. Ms. Mrs. Dr. First Name: \_\_\_\_\_ MI: \_\_\_\_ Last Name: \_\_\_\_\_

(circle one)

Male | Female DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ E-Mail Address: \_\_\_\_\_

Address (include apartment or unit #): \_\_\_\_\_

City: \_\_\_\_\_ State (Province): \_\_\_\_\_

Zip (Postal Code): \_\_\_\_\_ Country: \_\_\_\_\_

Home Phone (include area code): \_\_\_\_\_ Other Phone: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Physician Phone: \_\_\_\_\_

For which Healthy Weight Center program are you registering? (please check one):

- Working Off Weight (W.O.W.) – 4 month program
- Comprehensive Weight Management – 6 month program

*In order to have access to the web site and program support features you must select a unique username and password, as well as a reminder question and answer in case you lose your password. Your **Username** can contain letters and numbers only (no special characters) and your **Password** should not be something easily guessed (but something easily remembered).*

**NOTE** – To use betterMD.net, please disable any pop-up blockers and change your email/spam filter settings to accept important email from betterMD.net and MMHWC staff messages. Contact us if you need help with this.

Username: \_\_\_\_\_ Password: \_\_\_\_\_

Choose one of the following **Reminder Questions** by placing a checkmark in the appropriate box:

- What is your mother's maiden name?
- What was the name of your first pet?
- Whom do you most admire?
- What elementary school did you attend?

**Record your answer here:** \_\_\_\_\_

***In accordance with the NOTICE OF PRIVACY PRACTICES that you previously read and signed at Munson Medical Healthy Weight Center (MMHWC), this notice informs you that the MMHWC will share the information contained in this document and other information gathered during your participation in the Weight Management Program with the company betterMD.net, Inc. By signing below you are indicating that you previously read the above stated notice and are fully aware of, and will allow, the sharing of your weight management related information with betterMD.net, Inc.***

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

# MUNSON MEDICAL CENTER

## Healthy Weight Center

### Enrollment Form

In order for us to process your enrollment form quickly and accurately, please print legibly and be sure to complete the entire form prior to the orientation meeting. If you are unsure of what to do please ask for assistance from a staff member at the orientation.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

What was your weight at age 18? \_\_\_\_\_ Highest adult weight? \_\_\_\_\_ Lowest adult weight? \_\_\_\_\_

If you could weigh whatever you wanted, what would your "dream weight" be? \_\_\_\_\_

At what weight do you feel you would be happy? \_\_\_\_\_ What weight would be "acceptable" to you? \_\_\_\_\_

At what weight (less than your current weight) would you still be disappointed? \_\_\_\_\_

What weight do you have in mind to achieve as your "goal weight" through this program? \_\_\_\_\_

Please indicate which weight loss medications you have used in the past (check all that apply):

- |   |  |                               |
|---|--|-------------------------------|
| <input type="checkbox"/> Phentermine          | <input type="checkbox"/> Meridia®            | <input type="checkbox"/> None |
| <input type="checkbox"/> Fenfluramine         | <input type="checkbox"/> Xenical®            |                               |
| <input type="checkbox"/> Dexfenfluramine      | <input type="checkbox"/> Wellbutrin          |                               |
| <input type="checkbox"/> Phen/Fen combination | <input type="checkbox"/> Other (list): _____ |                               |

Are you pregnant?  Yes  No  NA Are you planning a pregnancy in the near future?  Yes  No  NA

Are you currently breast feeding (lactating)?  Yes  No  NA

Indicate which of the following conditions you have suffered or currently suffer from (choose all that apply):

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Heart Attack              | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> PCOS                     |
| <input type="checkbox"/> Heart Failure             | <input type="checkbox"/> Osteoarthritis      | <input type="checkbox"/> GERD (acid reflux)       |
| <input type="checkbox"/> Heart Valvular Disease    | <input type="checkbox"/> Sleep Apnea         | <input type="checkbox"/> Fibromyalgia             |
| <input type="checkbox"/> Neurological Disease      | <input type="checkbox"/> Type 1 Diabetes     | <input type="checkbox"/> Other (list types below) |
| <input type="checkbox"/> Bowel Disease             | <input type="checkbox"/> Type 2 Diabetes     | <input type="checkbox"/> None                     |
| <input type="checkbox"/> Kidney Disease            | <input type="checkbox"/> Thyroid Disease     |   |
| <input type="checkbox"/> NASH (fatty liver)        | <input type="checkbox"/> Depression          |   |
| <input type="checkbox"/> Liver Disease (severe)    | <input type="checkbox"/> Anemia              |   |
| <input type="checkbox"/> Cancer (list types below) | <input type="checkbox"/> Gout                |   |

Other diseases or illnesses: \_\_\_\_\_

Types of cancer: \_\_\_\_\_

Smoking? (choose one):

Never smoked  Quit smoking  Less than pack/day  Up to 2 packs/day  More than 2 packs/day

If you smoke or used to smoke, How long? \_\_\_\_\_ yrs. If you quit smoking, when? (date) \_\_\_\_\_

Do you use alcohol? (choose one):

Never  Quit drinking  Less than 3 drinks/week  Up to 14 drinks/week  More than 14 drinks/week

# MUNSON MEDICAL CENTER

## Healthy Weight Center

### Enrollment Form

Has any member of your immediate family (parents, brothers, sisters) ever had: (choose all that apply):

- |  |  |                               |
|--|--|-------------------------------|
| <input type="checkbox"/> Cardiovascular disease      | <input type="checkbox"/> Breast Cancer       | <input type="checkbox"/> None |
| <input type="checkbox"/> Diabetes (type 1 or type 2) | <input type="checkbox"/> Colon Cancer        |                               |
| <input type="checkbox"/> Gout                        | <input type="checkbox"/> Lung Cancer         |                               |
| <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Ovarian Cancer      |                               |
| <input type="checkbox"/> Obesity                     | <input type="checkbox"/> Prostate Cancer     |                               |
| <input type="checkbox"/> Osteoarthritis              | <input type="checkbox"/> Other Cancer        |                               |
| <input type="checkbox"/> Sleep Apnea                 | <input type="checkbox"/> Alcoholism          |                               |
| <input type="checkbox"/> Stroke                      | <input type="checkbox"/> Other (list): _____ |                               |

Indicate what types of medication you are currently taking (prescription and over the counter - choose all that apply):

- |  |   |                               |
|--|---|-------------------------------|
| <input type="checkbox"/> NONE                    | <input type="checkbox"/> for Depression     | <input type="checkbox"/> None |
| <input type="checkbox"/> for Weight Loss         | <input type="checkbox"/> for Anxiety        |                               |
| <input type="checkbox"/> for High Blood Pressure | <input type="checkbox"/> for Sleep          |                               |
| <input type="checkbox"/> for Heart Disease       | <input type="checkbox"/> for Hypothyroidism |                               |
| <input type="checkbox"/> for Birth Control       | <input type="checkbox"/> for Gout           |                               |
| <input type="checkbox"/> for Hormone Replacement | <input type="checkbox"/> for Allergies      |                               |
| <input type="checkbox"/> for Diabetes            | <input type="checkbox"/> OTHER              |                               |

List ALL medication you are currently taking in the box below (prescription and over the counter, including vitamins – include the name of the medication, dosage, and frequency for each medicine):  I am not taking any prescription medications

List any medication allergies: \_\_\_\_\_  None

List any food allergies: \_\_\_\_\_  None

List any hospitalizations for surgery, major illness or injury that required an overnight stay (include date):

\_\_\_\_\_  None

# MUNSON MEDICAL CENTER

## Healthy Weight Center

### Enrollment Form

Indicate what symptoms you are currently experiencing (choose all that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> Vision problems     | <input type="checkbox"/> Vaginal bleeding        |
| <input type="checkbox"/> Hearing problems    | <input type="checkbox"/> Unusual skin lumps      |
| <input type="checkbox"/> Swallowing problems | <input type="checkbox"/> Breast lumps or changes |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Pain in hands           |
| <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Pain in feet            |
| <input type="checkbox"/> Palpitations        | <input type="checkbox"/> Pain in hips            |
| <input type="checkbox"/> Wheezing            | <input type="checkbox"/> Pain in knees           |
| <input type="checkbox"/> Indigestion/Nausea  | <input type="checkbox"/> Pain in back            |
| <input type="checkbox"/> Lactose intolerance | <input type="checkbox"/> Pain in neck            |
| <input type="checkbox"/> Abdominal pain      | <input type="checkbox"/> Pain in shoulder        |
| <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> Pain in elbow           |
| <input type="checkbox"/> Constipation        | <input type="checkbox"/> Skin rash               |
| <input type="checkbox"/> Vomiting            | <input type="checkbox"/> Numbness/Tingling       |
| <input type="checkbox"/> Rectal Bleeding     | <input type="checkbox"/> Trouble walking         |
| <input type="checkbox"/> None                | <input type="checkbox"/> Other (list) _____      |

Do you have a history of: (choose all that apply)

- |                     |                                |                               |                                  |
|---------------------|--------------------------------|-------------------------------|----------------------------------|
| Anorexia            | <input type="checkbox"/> Never | <input type="checkbox"/> Past | <input type="checkbox"/> Present |
| Bulimia             | <input type="checkbox"/> Never | <input type="checkbox"/> Past | <input type="checkbox"/> Present |
| Binge eating        | <input type="checkbox"/> Never | <input type="checkbox"/> Past | <input type="checkbox"/> Present |
| Incest/sexual abuse | <input type="checkbox"/> Never | <input type="checkbox"/> Past | <input type="checkbox"/> Present |

Once you have completed page two through page five of this enrollment form, be sure to sign and date below. Page six and seven will be completed by a staff member at the conclusion of your Orientation meeting.

**Important Note** – You must hand in your registration and enrollment forms, as well as your physician's authorization before your program start appointment will be scheduled. If you have any questions, please contact one of the Munson Medical Healthy Weight Center staff members.

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

**MUNSON MEDICAL CENTER**  
**Healthy Weight Center**

**Enrollment Form**

**STAFF USE ONLY**

**Physical Exam Worksheet**

Patient Name of Record: \_\_\_\_\_

EMR Identification Number: \_\_\_\_\_

Height: \_\_\_\_\_ inches      Weight: \_\_\_\_\_ lbs.      Waist Circumference: \_\_\_\_\_ inches

Hip Circumference: \_\_\_\_\_ inches      BP: \_\_\_\_\_/\_\_\_\_\_      Heart Rate: \_\_\_\_\_ bpm.

Lab values:  Labs recorded below (drawn on: \_\_\_/\_\_\_/\_\_\_)     Labs requested     Labs not required

Tot Cholesterol: \_\_\_\_\_      LDL: \_\_\_\_\_      HDL: \_\_\_\_\_      Triglycerides: \_\_\_\_\_

Hgb A1c: \_\_\_\_\_      Fasting Glucose: \_\_\_\_\_      Thyroid (TSH) : \_\_\_\_\_

For which Healthy Weight Center program is this patient enrolling? (please check one):

- Working Off Weight (W.O.W.) – 4 month program
- Comprehensive Weight Management – 6 month program

Visit setting:     Individual session     Group session

These GOAL Weight entries require body mass measurements - DO NOT record weight LOSS goals

Initial weight goal: I want to weigh \_\_\_\_\_ lbs. in 4 weeks

Long-term weight goal: I want to weigh \_\_\_\_\_ lbs. eventually

Motivations to lose weight (choose two)

- improve health       improve appearance       feel better       live longer
- wishes of family members       wishes of friends or others

OTHER (not listed): \_\_\_\_\_

Barriers to success (choose two)

- exercise       lack of motivation       poor food preparation       poor food choices
- inability to control eating/portion sizes       lack of time       money
- lack of support from family or others

OTHER (not listed): \_\_\_\_\_



# MUNSON MEDICAL CENTER

## Comprehensive Weight Management Program

### Meal Plan Options

*All diet plans are supported by medical research as effective means for losing weight.*

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#### **Meal Plan: Hypocaloric**

This plan has been designed to provide optimum nutrition that will help you lose or control your weight and maintain health. Along with regular exercise and lifestyle education, this plan is designed to help you lose 1-2 pounds per week, although results may vary from person to person. This plan includes the use of whole foods that are portion based on food groups and calorie content, but can also include the use of meal replacement supplements. The calorie range for this plan is 1,200 to 1,600 calories per day. Eating from a wide variety of foods provides better overall nutrition.

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#### **Meal Plan: Partial Meal Replacement**

This plan uses a structured diet of pre-packaged entrees (purchased at the grocery store), dairy products, fruits and vegetables, plus approximately 4 packets of meal replacement supplements (purchased from our vendor) per day. This plan along with regular exercise and lifestyle education is designed to help you lose 2-3 pounds per week. The calorie range for this is 1,000-1,200 calories per day. This plan may be recommended for those who are 25 to 50 pounds overweight.

*There is an additional cost of approximately \$41-62 per week for supplements.*

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#### **Meal Plan: Total Meal Replacement**

This plan exclusively uses protein based meal replacement supplements. The typical plan equals 600-800 calories per day. For safe progress, patients on this plan may be required to make and attend follow-up visits at the Healthy Weight Center Clinic with our program Medical Director, or with your own Primary Care Provider. These appointments are not included in the program fee. This plan along with regular exercise and lifestyle education is designed to help you lose 3-5 pounds per week, and is best for those who are 25 – 100+ pounds overweight.

*There is an additional cost of approximately \$65-88 per week for supplements.*

# MUNSON MEDICAL CENTER

## Comprehensive Weight Management Program

### Scheduling Guide

#### **Intake Assessment**

A 90-minute appointment used to determine your readiness for the program.

#### **Meal Plan Start Appointment**

A 60-minute appointment to teach you everything you need to know about your meal plan.

#### **Registered Dietitian**      *Appointment duration: 30 minutes*

Depending on need, schedule ten to sixteen to half-hour sessions based on your registered dietitian's recommendations. You must attend a minimum of 10 sessions for successful completion of this portion.

#### **Behavioral Health**      *Appointment duration: 50 minutes*

At your first appointment, the behavioral health specialist will determine how many sessions are necessary. Five to eight sessions are available to you throughout your time in the program. You must attend a minimum of 5 sessions for successful completion of this portion.

#### **Exercise Physiologist**      *Appointment duration: 30 minutes of 1 on 1, 60 minutes total*

Seven (7) individual sessions required. Your first session will be one hour in duration; the remaining six will be half-hour in duration. You must plan for half-hour of cardio (on your own) **before** your individual sessions with the exercise physiologist. You must attend a minimum of 6 sessions for successful completion of this portion.

#### **Supervised Exercise**      *Appointment duration: 75 minutes*

One session required each week for a total of 12 sessions. Come at your scheduled time for this small group exercise session; staff to participant ratio is 1:8. Time allotted for these appointments allows for both cardiovascular exercise and resistance training. You must attend a minimum of 10 sessions for successful completion of this portion.

#### **Group Education**      *Appointment duration: 60 minutes*

Schedule a total of eight classes in the last eight weeks of the program (Class is held on Thursdays at 5:30 p.m.) Speakers for the classes will rotate between the Behavioral Health Specialist and the Registered Dietitian. Request class schedule for topics. You must attend a minimum of 6 classes for successful completion of this portion.

#### **Circuit Training**      *Appointment duration: 60 minutes*

This class follows the Group Education class on Thursday evenings. Circuit training begins at 6:30 p.m. and is located in the Physical Therapy Gym. You must attend a minimum of 6 sessions for successful completion of this portion.

*We do have a 24-hour cancellation policy. If you need to make any changes in your schedule, please do so at least 24 actual hours in advance by calling (231) 935-8533. **Messages left are time/date stamped. Cancellations with less than 24 actual hours advanced notice or no-shows cannot be made up.** A total of 3 missed appointments may lead to dismissal from the program.*