Lindsborg Community Hospital
Salina Regional Health Center
Family Health Care Clinic
605 W Lincoln • Lindsborg, KS 67456 • 785-227-3371 • FAX 785-227-3004 • www.lindsborghospital.org

Enrollment Packet

Thank you for your interest in ***Lifestyle Health***

Prior to your first appointment, please complete the following forms so that we can get to know you and design a program to meet your specific needs.

- Carbohydrate Quiz
- Motivational Source Inventory
- Nutritional History
- Patient Health Questionnaire (PHQ-9)
- Snore Score Questionnaire
- Consent Form (wait to sign this until you meet with Greg)

At your first appointment you will meet with a health coach who will complete the following prior to you meeting with Greg Lindholm, PA or Jade Banning, PA

- Body Composition Analysis (a special scale to stand on)
- Blood pressure, and pulse
- Waist Circumference & other measurements
- "Before" picture (optional)

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Name: _____Date of Birth:_____

CARBOHYDRATE QUIZ

1. After a full breakfast, do you get hungry before it's time for lunch?
   Yes___ No___

2. Do you have a difficult time stopping once you start to eat starches, snack foods, junk food or sweets?
   Yes___ No___

3. Do you sometimes eat even though you are not really hungry?
   Yes___ No___

4. Are you sometimes unable to keep from snacking at night?
   Yes___ No___

5. After a large meal, do you feel very sluggish, almost drugged?
   Yes___ No___

6. Do you get unexplainably tired and/or hungry in the afternoon?
   Yes___ No___

7. Do you sometimes feel unsatisfied even though you have just finished a meal?
   Yes___ No___

8. Does the sight, smell, or even the thought of food sometimes stimulate you to eat when you are full?
   Yes___ No___

9. Have you, at times, continued eating even though you felt uncomfortably full?
   Yes___ No___

10. Have you been on diet after diet only to lose weight then regain it again?
    Yes___ No___

MOTIVATIONAL SOURCE INVENTORY

For each question below, please circle the number that most accurately represents how you have felt most of your life, rather than how you wish you could be.

NAME:_____

DATE:_____

	Almost Never			Sometimes				Most of the Time		
1) Compared to others, I tend to have higher ethical standards.	1	2	3	4	5	6	7	8	9	10
2) It is important for me to help others, even if they don't ask for help.	1	2	3	4	5	6	7	8	9	10
3) I usually go full force until the job is completely finished.	1	2	3	4	5	6	7	8	9	10
4) I worry more than others about whether I will ever be happy.	1	2	3	4	5	6	7	8	9	10
5) It is difficult for me to express my feelings to those I care about.	1	2	3	4	5	6	7	8	9	10
6) I tend to care more about the importance of members of the family spending time together than other family members.	1	2	3	4	5	6	7	8	9	10
7) I tend to get bored before I complete long-term projects.	1	2	3	4	5	6	7	8	9	10
8) I enjoy being more assertive and stronger than others.	1	2	3	4	5	6	7	8	9	10
9) Making choices can be difficult because I can see the advantages and disadvantages of most options.	1	2	3	4	5	6	7	8	9	10
10) I feel good when every detail is done to perfection.	1	2	3	4	5	6	7	8	9	10
11) I enjoy helping people to do what is best for them.	1	2	3	4	5	6	7	8	9	10
12) A portion of my success is because I project a more successful image than others.	1	2	3	4	5	6	7	8	9	10
13) I tend to be more sensitive and emotional than others.	1	2	3	4	5	6	7	8	9	10
14) I would rather begin a new *project* by observing and studying rather than just jumping in and doing it.	1	2	3	4	5	6	7	8	9	10
15) I am usually much more organized than others.	1	2	3	4	5	6	7	8	9	10
16) I always want to do many different kinds of things, which makes it difficult to focus on becoming an expert at one thing.	1	2	3	4	5	6	7	8	9	10
17) I am direct and honest with most people even though they may be uncomfortable with my bluntness.	1	2	3	4	5	6	7	8	9	10

	Almost Never			Sometimes				Most of the Time		
18) I usually prefer walking away from a disagreement rather than confronting someone.	1	2	3	4	5	6	7	8	9	10
19) I tend to see things as black or white with few shades of gray.	1	2	3	4	5	6	7	8	9	10
20) It is easy for me to see the potential in others and I enjoy assisting them in doing their best.	1	2	3	4	5	6	7	8	9	10
21) I have the ability to see how to cut corners in projects to make sure I do the best job.	1	2	3	4	5	6	7	8	9	10
22) My sad moods are important to me, because they help me keep in touch with my feelings.	1	2	3	4	5	6	7	8	9	10
23) Conserving my energy and my money is always one of my major concerns.	1	2	3	4	5	6	7	8	9	10
24) I constantly question myself about what might go wrong.	1	2	3	4	5	6	7	8	9	10
25) My style tends to be to go from one task to another, because I like to keep on the move.	1	2	3	4	5	6	7	8	9	10
26) I enjoy situations where I have to be strong to protect others.	1	2	3	4	5	6	7	8	9	10
27) In general, I have placed other people's needs before my own.	1	2	3	4	5	6	7	8	9	10
28) It makes me angry that some people are late for almost everything.	1	2	3	4	5	6	7	8	9	10
29) I am comfortable jumping in and rescuing people, even if they do not understand the trouble they are in.	1	2	3	4	5	6	7	8	9	10
30) I have liked to let people know what I have accomplished.	1	2	3	4	5	6	7	8	9	10
31) My deepest feelings are expressed through my special creativity.	1	2	3	4	5	6	7	8	9	10
32) I dislike most social events. I'd rather be alone or with a few people I know very well.	1	2	3	4	5	6	7	8	9	10
33) I worry more about the safety of my family and friends than they worry about themselves.	1	2	3	4	5	6	7	8	9	10
34) I have always enjoyed many kinds of interests and experiences, as long as they are not dangerous.	1	2	3	4	5	6	7	8	9	10
35) My self-reliance and strength has been a key to my success in helping the less fortunate.	1	2	3	4	5	6	7	8	9	10
36) I go out of my way to avoid conflict and usually prefer neutral positions.	1	2	3	4	5	6	7	8	9	10
37) I tend to have been highly critical of myself and others.	1	2	3	4	5	6	7	8	9	10
38) I have worked much harder than others to make my relationships successful.	1	2	3	4	5	6	7	8	9	10
39) I have gone after and achieved goals that have excellent potential for personal reward or recognition.	1	2	3	4	5	6	7	8	9	10
40) It is easy for me to understand my honest feelings.	1	2	3	4	5	6	7	8	9	10
41) I usually get tired when I have been with people for very long.	1	2	3	4	5	6	7	8	9	10
42) I have a tendency to immediately see how things could go wrong.	1	2	3	4	5	6	7	8	9	10
43) Some people don't understand how easily I see the brighter sides of unpleasant situations.	1	2	3	4	5	6	7	8	9	10
44) I may get angry quicker than most, but it's usually justified.	1	2	3	4	5	6	7	8	9	10

	Almost Never						Sometimes			Most of the Time
45) I have a tendency to wait until the last minute to complete the most important tasks.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
46) I tend to get very angry at people that rarely follow the rules.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
47) I frequently have become emotionally drained from taking care of other people's needs.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
48) Many people find me attractive because of my achievements.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
49) Being understood has been very important to me.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
50) I like to feel invisible, and it surprises me when anyone notices anything about me.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
51) I prefer things to stay the same, change is frequently very uncomfortable.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
52) Even if I set the rules, I am uncomfortable with limited options.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
53) I am usually the one that makes the rules.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
54) Frequently, it is hard for me to get started, but once started, it is easy for me to keep going.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Place your answers to the above questions in the corresponding boxes below.
Then add the rows across and place the totals at the box at the end of each row.

1	10	19	28	37	46	[one]
2	11	20	29	38	47	[two]
3	12	21	30	39	48	[three]
4	13	22	31	40	49	[four]
5	14	23	32	41	50	[five]
6	15	24	33	42	51	[six]
7	16	25	34	43	52	[seven]
8	17	26	35	44	53	[eight]
9	18	27	36	45	54	[nine]

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NUTRITION HISTORY

Are you concerned about your current weight?

❑ NO ❑ YES

List up to 5 things that are currently motivating you to lose weight:

1. _____
2. _____
3. _____
4. _____
5. _____

What is your goal weight? _____

What was your lowest adult weight?_____What was your age at that weight? _____
What was your highest adult weight? _____ What was your age at that weight? _____

Are you able to pinpoint when you began to gain weight and why, if known?

_____
_____

Please list any dietary or nutritional supplements that you take on a regular basis:

_____
_____
_____
_____

Have you lost weight in the past? ❑ Yes ❑ NO
What worked best for you and why? _____
_____

If you answered yes to the question above, please answer the following:
Describe the type of diet_____

Did you lose weight? ❑ Yes ❑ NO
How many pounds _____ over _____months.
Have you regained any of this weight? ❑ YES ❑ NO
If yes, why do you think you regained the weight? _____

Are you now, or have you ever taken medications to lose weight? ❑ YES ❑ NO
Name of medication (s)_____

What obstacles do you see right now in your life that is not allowing you to make personal changes in how you eat and excercies?_____

Is your spouse overweight? ❑ YES ❑ NO

How many meals in a week do you eat out? (circle one) 1 2 3 4 5 +
What restaurants do you frequent? _____
Who is the family meal planner? _____ The cook? _____
Food shopper? _____

Is there any special time of the day that you crave foods? _____
What are some foods that you crave? _____
What foods do you dislike? _____

Please complete:

	Soft-drinks	Alcohol
Type	_____	_____
Frequency	_____	_____
Quantity	_____	_____

How frequently do you consume items with sugar substitutes? _____
Do you awake hungry at night? ❑ YES ❑ NO
List your worst food habits? _____

Lifestyle changes are changes to improve your health, such as adjusting your diet, increasing physical activity and changing health related behaviors.

Put an X on the line below to indicate on a scale of 1-10
How <u>important</u> it is for you to make lifestyle changes.
0_____5_____10
Not important Somewhat Very Important

How ready are you right now to make changes?

0_____5_____10

How confident are you that you can make changes?

0_____5_____10

What is your current level of stress?

0_____5_____10

Are you a stress eater? ❑ YES ❑ NO

Indicate your current activity level

_____ Inactive – no regular physical activity with a sit down job

_____ Light Activity – no organized physical activity during leisure time

_____ Moderate Activity – occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.

_____ Heavy Activity – consistent lifting, stair climbing, heavy construction or regular participation in jogging, swimming, cycling or active sports at least 3 times per week.

_____ Vigorous Activity – participation in extensive physical activity for at least 60 minutes per session 4 times per week.

Behavior style:

_____You are *always* calm and easy going.

_____You are *usually* calm and easy going.

_____You are *sometime*s calm with frequent impatience.

_____You are *seldom* calm and persistently driving for advancement.

_____You are *never* calm and have over whelming ambition.

_____You are *hard driving* and can never relax.

Please describe your typical meals on weekdays and weekends:

Typical breakfast on weekday: Typical breakfast on a weekend:

_____ _____

_____ _____

_____ _____

Typical Lunch on a weekday:

_____

_____

_____

Typical lunch on a weekend:

_____

_____

_____

Typical Dinner on a weekday:

_____

_____

_____

Typical dinner on a weekend:

_____

_____

_____

Typical weekday snacks:

_____

_____

_____

Typical weekend snacks:

_____

_____

_____

You're done with the nutritional history ☺

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last *2 weeks*, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)

	Not at All	Several days	More than half the days	Nearly every day
1. Little Interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
Add columns		+		

(Healthcare professional: For interpretation of TOTAL, Please refer to accompanying scoring card).

TOTAL: _____

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely Difficult _____

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WHAT'S YOUR SNORE SCORE?

1. Are you a loud and/or regular snorer? □ Yes □No
2. Have you ever been observed to gasp or stop breathing during sleep?
   ❑ Yes ❑ No
3. Do you feel tired or groggy upon awakening, or do you awaken with a headache?
   ❑ Yes ❑ No
4. Are you often tired or fatigued during the wake time hours?
   ❑ Yes ❑ No
5. Do you fall asleep sitting, reading, watching TV or driving?
   ❑ Yes ❑ No
6. Do you often have problems with memory or concentration?
   □Yes ❑ No

Name: _____DOB: _____

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Lifestyle Health Consent Form

I, _____ , authorize Greg Lindholm, P.A. , Jade Banning, PA-C and Ben Dolezal, M.D. to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for duration exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastro intestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that if I am seeing Greg or Jade for weight management this does not mean he is my primary care provider (PCP). I will continue to see my PCP for medical concerns not related to weight management.

I understand that much of the success of the program will depend on my efforts and that there are not guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

I have asked any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments.

Date:_____ Time: _____

Patient signature: _____

Printed name: _____