Paperwork for Nutrition Counseling or Healthy Living Services

HEALTHY LIVING™
DIABETES & ENDOCRINOLOGY CENTER OF OHIO

Patient Name: _____

Is scheduled for an appointment with: **Jennifer McCann, MS, RDN, LD**
for
☐ DECO Healthy Living Weight Loss Program ☐ Nutrition Counseling

On _____ at _____ AM/PM

- **Please plan to arrive 10 minutes prior to your scheduled appointment time to allow for paperwork processing and check in procedures.**
- **If you are unable to arrive by your scheduled appointment time it may be necessary to reschedule your appointment. Please call if you are late or unable to make your scheduled time. Early notice appreciated.**
- **A current insurance card, prescription coverage card (if applicable), photo identification and any copay or coinsurance must be presented at check-in.**

In order to expedite the check-in process, please complete the attached paperwork **prior to** your appointment.

If able, please scan and e-mail paperwork 12 hrs before appointment to DecoDietitian@gmail.com
-Or you may bring completed day-of your appointment, please arrive early-

If you have any questions regarding this paperwork or your visit, please contact our office at (614)764-0707

We are here to assist you Mon – Wed 7:30am-3:30pm, Thurs 8:00am-5:00pm, and Fri 7:30am-2:30pm

DECO, Inc.
7281 Sawmill Road
Dublin, Ohio 43016

****Please be sure to complete all following pages in this packet****

CURRENT DECO PATIENT NUTRITION PAPERWORK NAME:_____ DATE_____

Weight and Nutrition History Questionnaire

Have you seen a Registered Dietitian before? □ Yes □ No **How recently?** _____
What is your reason for seeing DECO's Registered Dietitian? □ Weight loss needs □ Weight gain needs □ Carb counting education □ Recent diagnosis and confusion with diet needs/changes (**please note diagnosis**:_____) □ Other _____

****Please skip any questions that are not relevant to your needs (i.e. if you are not seeing the dietitian for weight loss)****

When did you begin or have significant weight gain?
□ Since Adolescence □ After Pregnancy □ After Employment Change □ During a Stressful Period □ After Marriage □ Other _____
If applicable, how long have you been clinically overweight (BMI >25)?
□ 1 year or less □ 2-5 years □ 6-10 years □ Over 10 years
How many meals do you eat daily? _____ Do you eat a snack(s) during the day? □Yes □No
Have you made attempts to 'diet', follow a meal plan, or partake in a weight loss program? □Yes □No **How many? _____ How long have you stayed on a 'diet' or been with a weight loss program?**
□ 0-2 months □ 3-6 months □ 7-12 months □ Over 12 months
What weight loss or diet change methods have you tried in the last 5 years?
□ Weight Watchers □ Diet Books □ Weight Loss Medications □ Other Diet Centers □ Physicians □ Do It Yourself □ Other _____
If applicable, why have you dropped out of or discontinued other intake changes or weight loss programs before?
_____

Are you under a physician's care? □ Yes □ No **Have you been advised by a physician to lose weight?** □ Yes □ No
Do you have any medical problems that you know are associated with your weight (under, over, or average weight)? □ Yes □ No

(If desired) How important is it to you to lose weight?
□ Extremely Important □ Very Important □ Important □ Not Very Important □ N/A
Why do you want to lose weight?
□Promote social activity □Appearance □Special Occasion □Health Reasons □To Please Others □Other _____

Marital Status? □Single □Married □Divorced □Widowed □Living with partner
Has your spouse/partner encouraged you to lose weight? □ Yes □ No □ N/A **Do you feel supported in your goals?** □ Yes □ No
Number of children (if applicable):_____ Ages?_____

Do You work outside of the home? □ Yes □ No **Occupation?** _____
Current weight? _____ Have you lost or gained any weight in the last 12 months? □ Yes □ No **If yes, How much?**_____
Goal weight (not required) _____ Highest weight in last 5 years? _____ Lowest weight in last 5 years? _____

Do you consume alcohol? □ Yes □ No **Type consumed?** □ Wine □ Beer □ Liquor **Frequency?** □ <1x/month □ 2x/month □ Weekly □ Daily
How often do you exercise? □ Rarely □ Occasionally □ 1-2 times per week □ 3-4 times per week □ 5 or more times per week
Type of exercise you do:_____ **length of time:** _____
Has a doctor or other health care professional ever told you not to exercise? □ Yes □ No
Do you know any reason why you should not exercise? □ Yes □ No **If yes why?** _____

How many meals out per week? _____ Are these most often sit down, take out, fast food, or a combination? _____
What meal is normally eaten out? □ Breakfast □ Lunch □ Dinner **Are these meals with family or friends?** □ Yes □ No

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 □Not paying attention to what I'm eating □Eating high-fat foods □Eating too many sweet foods
□Eating foods too quickly □Uncontrollable binges □Eating in reaction to emotions □Eating to take my mind off other problems
□Overeating at social events □Lack of satisfaction in life □Eating in reaction to boredom □Overeating when alone
□Using food as a reward □Eating too many carbs □Grazing through the day □ I'm not sure what's a good choice □ Other _____

Are you presently going through any major lifestyle change (marriage, divorce, job change, move, illness, death of a loved one?)
_____

List 3 reasons it is important to be at a healthy weight for you.
1) _____
2) _____
3) _____

CURRENT DECO PATIENT NUTRITION PAPERWORK NAME:_____ DATE_____

Please List any current vitamins/minerals, supplements not on your current DECO Medication list and/or any recent medicine changes since you were last at a DECO visit:

_____

_____

Please list any food allergies:

_____

Please note *strongly disliked* foods or foods you feel cause you GI or other concerns:

_____

Are you currently or regularly experiencing symptoms of: □ Nausea □ Vomiting □ Diarrhea □ Constipation □ Gas □ Reflux

Do you follow a special diet? □ None □ 'Diabetic' □ Low carb □ Gluten Free □ Low Salt □ Vegetarian □ Vegan □ Paleo □ Other

_____

Do you suffer of have ever suffered from depression, anxiety, insomnia, or disordered sleep patterns?

_____

Do you or have you ever experienced disordered eating patterns not yet discussed, i.e. anorexia, binging, and/or purging? □ Yes □ No
If yes to above, is this a current concern? □ Yes □ No
Have you or are you currently seeking treatment? □ Yes □ No

Please describe your 'Typical Day' food intake:

Meal./drink/ time of day	**"Good Day"**	**"Bad day"**
Breakfast **Time:**		
Lunch: **Time:**		
Dinner: **Time:**		
Snack(s) **Time(s):**		
Fluid intake **(oz/day and type)**		

STOP- If the DECO Healthy Living Weight Loss Program is **not** the reason you are seeing the dietitian, please **skip** the following section and move on to the **Cancellation/ No-Show Policy on page 7**

DECO HEALTHY LIVING QUESTIONNAIRE: for each question, please circle the answer, that best describes how you feel

Section 1: Goals and Attitudes

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

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

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	5
Not At All Certain	Slightly Certain	Somewhat Certain	Quite Certain	Extremely Certain

Consider all outside factors currently 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 meal plan?

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

Think honestly about how much weight you hope to lose and how quickly you hope to lose it. Figuring a weight loss of 0.5 to 2 pounds per week while on the FULL Healthy Living program, how realistic is this expectation to you?

1	2	3	4	5
Very Unrealistic	Somewhat Unrealistic	Unsure (But I'm willing to try!)	Somewhat Realistic	Very Realistic

If going on a meal plan, do you fantasize about eating a lot of your favorite foods?

1	2	3	4	5
Always	Frequently	Occasionally	Rarely	Never

When starting on a meal plan, do you feel deprived, angry and/or upset?

1	2	3	4	5
Always	Frequently	Occasionally	Rarely	Never

Section 1 TOTAL SCORE_____

If you scored:

6 to 16:	This may not be a good time for you to start a weight loss program. Low motivation and commitment together with unrealistic goals could block your progress. Think about those things that contribute to this and consider how you may change them before undertaking a formal weight loss program. Maybe start with Nutrition Counseling only.
17 to 23:	You may be close to being ready to begin a program but should think about ways to boost your preparedness before you begin. Try making a list of pros vs. cons for starting a formal weight loss program or list *reasons* to lose weight for YOU.
24 to 30:	The path is clear with respect to goals and attitudes.

Section 2: Hunger and Eating Cues

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

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

How often do you eat because of physical hunger?

1	2	3	4	5
Always	Frequently	Occasionally	Rarely	Never

Do you have trouble controlling your intake/ portion when your favorite foods are around the house?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

Section 2 TOTAL SCORE_____

If you scored:

3 to 6:	You might occasionally eat more than you would like, but it does not appear to be a result of high responsiveness to environmental cues. Controlling the reasons that make you eat may be especially helpful.
7 to 9:	You may have a moderate tendency to eat just because food is available. Having a meal plan may be easier for you if you try to resist external cues and eat only when you are becoming physically hungry.
10 to 15:	Some or most of your eating may be in response to thinking about food or exposing yourself to temptations to eat. Think of ways to minimize your exposure to temptations so that you eat only in response to physical hunger. (And not waiting until we are 'starving' as this can leas to over-indulging as well)

Section 3: Control Over Eating

If the following situations occurred while you were following a meal plan, would you be likely to eat more, less, or no different?

Although you packed or had your lunch planned, a friend talks you into going out to lunch.

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

You "break" your meal plan by eating a less ideal, "forbidden" food. (***note****: there are no 'forbidden foods' just moderation and healthier choices*)

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

You have been following your meal plan 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_____

If you scored:

3 to 7:	You recover rapidly from "going off-track". However, if you frequently alternate between eating out of control and dieting strictly, you may have a disordered eating pattern and should seek professional guidance.
8 to 11:	You do not seem to let unplanned eating disrupt your program. This is a flexible, balanced approach.
12 to 15:	You may be prone to overeat after an event breaks your control or throws you off track. Let's focus on your reactions to these problem-causing events or 'barriers to success' as they can be improved.

Section 4: Binge Eating and Purging

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

If you answered yes above, how often have you engaged in this behavior during the last 12 months?

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

Have you ever purged (used laxatives, diuretics, induced vomiting, or excessive exercise [>2 hours/day]) to control your weight?

2	0
Yes	No

If you answered yes above, how often have you engaged in this behavior during the last 12 months?

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_____

If you scored:

0 to 1:	It appears that binge eating, and purging, is not a current concern. *(Please discuss this in a judgment-free zone with our program's dietitian if you did not want to record any of the above behaviors on paper*)
2 to 9:	Pay attention to these eating patterns. Should they arise more frequently, please seek professional help. Treatment options can be discussed with your primary care provider, DECO physicians, or our program's dietitian.
10 to 16:	These results show signs of a potentially serious eating disorder or disordered eating pattern. Please discuss with your primary care provider, DECO physicians, or our program's dietitian to find a counselor experienced in this area.

Section 5: Emotional Eating

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

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

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_____

If you scored:

3 to 8:	You do not appear to let your emotions affect your eating.
9 to 11:	You sometimes eat in response to emotional highs and lows. Monitor this behavior to learn when and why it occurs and be prepared to find alternative activities.
12 to 15:	Emotional ups and downs can stimulate you're eating. Try to deal with feelings that trigger the eating and find other ways to express them.

Section 6: Exercise Patterns and Attitudes

How often do you exercise?

1	2	3	4	5
Never	Rarely	Occasionally	Somewhat	Frequently

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	5
Not At All Certain	Slightly Certain	Somewhat Certain	Quite Certain	Extremely Certain

Section 6 TOTAL SCORE_____

If you scored:

4 to 10:	You're probably not exercising as regularly as you should. Determine whether your attitudes about exercise are blocking your way, then change what you must and put on those walking shoes.
11 to 16:	You need to feel more positive about exercise, so you can do it more often. Think of ways to be more active that are fun and fit your lifestyle.
17 to 20:	It looks like the path is clear for you to be active. Now think of ways to get motivated.

STOP- The page is only for individuals interested in knowing more or starting the DECO Healthy Living Weight Loss Program, if you are not please move on to the **Cancellation/ No-Show Policy on page 7**

Side Effects Possible from a Modified Very Low-Calorie Diet

People on a very low-calorie diet may experience mild, temporary side effects as their body adjusts to the diet. Notify the dietitian or see your primary care doctor about any symptoms that persist or concern you. Side effects may include:

□ **Dizziness** - As you begin losing weight, you lose a lot of water as urine. This lowers blood volume and, hence blood pressure. To minimize dizziness, avoid changing positions quickly; don't use whirlpools, saunas or steam baths; and drink plenty of water.

□ **Fatigue, Dry Skin, Sensitivity to Cold -** These are generally mild and can be treated with extra rest, lotions/creams and extra clothing.

□ **'Fruity' Breath –** Ketosis is NOT our goal but may occur and temporarily give your breath a fruity odor, if this does occur, we will correct it.

□ **Gallstones -** Tell the dietitian about any symptoms or history of gallstones; you may require additional tests or treatment while on this program.

□ **Gastrointestinal Upset -** Changing from solid foods to a mostly liquid diet may cause constipation/diarrhea. Over the counter medications are available for either condition. In addition, your medical team can add a Fulfill Fiber product to your meal plan to help relieve constipation.

□ **Hair Loss -** A small percentage of patients may experience patchy hair loss 3-6 months into diet. Frequently, new hair grows as old hair is lost.

□ **Leg Cramps -** Drinking more fluids or increasing electrolytes can often relieve occasional or mild leg cramps. Your physician should evaluate any leg pain you are experiencing.

□ **Menstrual Irregularities -** Dietary changes may cause delayed or missed periods. Women who miss a period or have a late period should be tested for pregnancy.

Patient Commitment

I realize that losing weight will require a great deal of time and effort on my part; I wish to participate in the DECO Healthy Living Program. I understand that this program is medically monitored for weight loss and weight management.

□ I understand that my goal is to lose weight and to keep it off. I agree to participate in all phases of the program – Active Weight Loss, Adapting and Maintenance (S.T.A.R.).

□ I must meet medical and psychological screening requirements established by the DECO Healthy Living team. If medical complications unrelated to weight loss arise during the program, I understand that I will be referred back to my private physician.

□I understand that I must weigh in weekly. If I must miss a week, I will notify the dietitian 1 week before. Emergency situations will be excused.

□ I understand that in the BEST INTEREST OF MY HEALTH I must maintain my weight loss once I reach my goal.

□ I will make the commitment to understand and practice the lifestyle changes presented in the DECO Healthy Living Program.

□ If I find myself having difficulty, I will not hesitate to contact the DECO Dietitian (Jennifer) for assistance.

_____ _____

Patient Signature Date

Authorization for Examination and Treatment

Initials	Commitments
	Having been explained the risks and benefits of the DECO Healthy Living Program, a medically monitored program for rapid, safe weight loss and complete education to help manage weight, I knowingly and voluntarily desire to participate in the Program.
	I am aware that I must meet medical and psychological screening requirements established by the DECO Healthy Living Team before entering the Program.
	I hereby authorize and consent to have the DECO Healthy Living Program physicians to order complete physical and diagnostic procedures including blood tests, electrocardiogram (EKG), and possible a stress test and/or chest radiography for evaluation purposes. I have had and will have the opportunity to ask questions regarding the diagnostic procedures and my health.
	As part of the DECO Healthy Living Program, continuous medical monitoring is mandatory. Consequently, upon acceptance into the Program, I willingly agree to have this monitoring performed (blood tests, periodic EKG and other tests as indicated).
	I am aware during the weight loss period possible side effects may occur from a modified very low-calorie intake. Possible Ketosis is an increased amount of fat by-products (ketone bodies) in the body due to altered nutrient composition of the diet (low carbohydrate). If this occurs, I will discuss with the program's dietitian to modify my meal plan. Other side effects include dizziness, fatigue, leg cramps, missed or late menstrual periods, dry skin, temporary hair loss, sensitivity to cold, diarrhea, and/or constipation.
	If medical complications unrelated to weight loss arise during the Program, I am fully aware I will be referred back to my private physician.
	I recognize that if I should become pregnant my participation in the Program must be terminated.

Dietitian Services Cancellation and No-Show Policy

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours' notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. When cancellations are made with less than 24 hours' notice, we are unable to offer that slot to other patients.

Consistent occurrences of any three of the following: no shows, late arrivals, or same day cancellations may lead to a discharge from the program. **No show appointments or appointments which are cancelled less than 12 hours in advance will be subject to a $10.00 'no-show' service fee**. *This will be strictly enforced for any reoccurring no show appointments*.

Patients who do not show up for their appointment without a call to cancel the appointment will be considered as NO SHOW. The cancellation and no-show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with the program director's approval. Our program firmly believes that good staff/patient relationship is based upon understanding and good communication.

Questions about cancellation and no-show fees should be directed to the program director at 614-764-0707.

_____ _____

Patient Signature Date

Consent for Service

Assigned of Insurance Benefits

I hereby authorize direct payments of medical benefits to Diabetes & Endocrinology Center of Ohio, Inc for services rendered by them in person or under their supervision. I understand that by signing this form, I am financially responsible for payment of any balances due.

Failure to complete all information may result in patient being billed directly for services.

Consent to Treatment

I hereby authorize treatment by the providers and staff as they deem medically necessary for conditions diagnosed.

Printed Name:_____**Date**_____

Patient Signature_____

CDC-Kaiser Adverse Childhood Experience (ACE) Study

Adverse Childhood Experiences - Linking Childhood Trauma to Long-Term Health and Social Consequences
A questionnaire was sent to over 13,000 adults who voluntarily participated in a study to find out about how stressful or traumatic experiences during childhood affect adult health and over 9,000 responses were received and processed.

Here's What Was Learned
Many people experience harsh events in their childhood. 64% of the people who participated in the study had experienced at least one category of childhood trauma. Over 20% experienced 3 or more categories of trauma or Adverse Childhood Experiences (ACEs). 11% experienced emotional abuse, 28% experienced physical abuse, 21% experienced sexual abuse, 15% experienced emotional neglect, 10% experienced physical neglect, 13% witnessed their mothers being treated violently, 27% grew up with someone in the household using alcohol and/or drugs,19% grew up with a mentally-ill person in the household, 23% lost a parent due to separation or divorce, 5% grew up with a household member in jail or prison.

The more categories of trauma experienced in childhood, the greater the likelihood of experiencing:
Coronary Artery Disease (CAD), Obesity, COPD, Poor Health-Related Quality of Life, Liver Disease, STD/STIs, Alcoholism/ Alcohol Abuse, Smoking, Depression, Unintended Pregnancies, Fetal Death, Multiple Sexual Partners, Illicit Drug Use, Suicide Attempts

Talk with your primary care doctor about what happened to you when you were a child. Ask for help. For more information about the ACE Study visit the Centers for Disease Control and Prevention at: www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/

Please complete the following questionnaire to learn your ACE score if you are comfortable doing so. We have found this questionnaire beneficial in improving and providing best outcomes in our nutrition counseling and Healthy Living services.

While you were growing up, prior to your 18th birthday:

1) Did a parent or any other adult in the household **often**……
Swear at you, insult you, put you down or humiliate you?
or
Act in a way that made you afraid that you might be physically hurt?
Yes No

2) Did a parent or any other adult in the household **often**……
Push, grab, slap or throw something at you?
or
Ever hit you so hard you had marks or were injured?
Yes No

3) Did an adult or person at least 5 years older than you **ever**……
Touch or fondle you or have you touch their body in a sexual way?
or
Attempt or actually have oral, anal, or vaginal intercourse with you?
Yes No

4) Did you **often** feel that……
No one in your family loved you or thought you were important or special?
or
Your family did not look out for each other, feel close to each other, or support each other?
Yes No

5) Did you **often** feel that……
You did not have enough to eat, had to wear dirty clothes, and had no one to protect you?
or
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes No

6) Were your parents **ever** separated or divorced?
Yes No

7) Was your mother or stepmother……
Often or very often pushed, grabbed, slapped or had something thrown at her?
or
Sometimes, often or very often kicked, bitten, hit with a fist or hit with something hard?
or
Ever repeatedly hit for at least a few minutes or threatened with a gun or knife?
Yes No

8) Did you live with anyone who was a problem drinker or alcoholic or anyone who used street drugs?
Yes No

9) Was a household member depressed or mentally ill, or did a household member attempt suicide?
Yes No

10) Did a household member go to prison?
Yes No

Each "Yes" answer is a score of 1

Please add up your "Yes" answers: _____This is your ACE Score

***The ACE score measure 10 types of childhood trauma, each type of trauma counts as one. This is not to discredit other forms of childhood trauma that are experiences- i.e. racism, bullying, death of loved ones- but is used to measure the most common traumas found and researched by Kaiser members. This is meant to be used as a guideline, not a definite risk to your health outcomes; however, a significant link between childhood trauma and chronic disease later in life has been supported. Therefore, the higher your ACE score, a higher risk of social, emotional, and health concerns may be present.**