Greg Hooper, M.D.

Weight Management Program

Remember that the decisions you make today can help you prevent many of the health related problems you may develop starting tomorrow!

Our program is built upon the 3 elements of success. They are diet & nutrition, medication & supplements, and exercise & hydration.

If any one of the components is not followed or utilized the likelihood of success decreases.

The efforts to overcome being overweight or obese are not easy. It may take you more than once to make the lifestyle changes necessary to end the struggle against your weight and adopt a healthy lifestyle.

We realize how difficult it can be and it is nothing to be embarrassed about. By restarting the program you are already taking the right steps to find success. Our hope for you on this occasion is that you make the right adjustments to solidify that success for the long term.

During your consultation with the restart consultant and the physician, you will find that they are going educate you on the new program and how we will help you to succeed. They are also going to review your previous records to make the necessary changes that will help you succeed in losing the weight and guide you in the long term maintenance.

The medical staff will also evaluate your health risks. Many of your risks may still be present or have worsened. Your body composition is a major component in many of these health risks. Other factors that will contribute to increased risks are genetics, nutrition, lifestyle, and a lack of supplements. The treatment plan you receive today will review these risks and recommend a plan to reduce these risks.

We hope that you chose Dr. Greg Hooper's Weight Management Program not only for your weight loss needs, but also for our medical expertise in providing you with treatment options to increase your overall health and Wellness.

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Weight Management Program

Patient Information (Please Print)

FIRST NAME	LAST NAME

DATE OF BIRTH	AGE	GENDER	SOCIAL SECURITY #
		☐ Male ☐ Female	

STREET ADDRESS	CITY	STATE	ZIP

EMPLOYER	OCCUPATION

WORK PHONE	HOME PHONE
Can we leave a message at this number? ☐ Yes ☐ No	Can we leave a message at this number? ☐ Yes ☐ No

CELL PHONE	EMAIL ADDRESS
Can we leave a message at this number? ☐ Yes ☐ No	

EMERGENCY CONTACT (Last Name, First Name)	PHONE NUMBER

Supporting you in your journey of weight loss and maintenance is very important to us. Therefore, from time to time, we may wish to send you information, samples or special offers that we may feel may be of interest to regarding Dr. Greg Hooper's Weight Management Program and/or Zone Wellness. We may also contact you in relation to consumer research, marketing and customer surveys. If you would rather not receive additional information and/or offers, please do not check the box below.

PRIVACY: Your information will be kept strictly confidential and not provided to any third parties.

☐ **Yes, I would like to receive such information & offers by postal mail**
☐ **Yes, I would like to receive such information & offers by phone**
☐ **Yes, I would like to receive such information & offers by email**

How did you learn about the program?	
☐ Patient Referral	☐ Newspaper (Please Identify):
☐ Magazine (Please Identify):	☐ Television (Please Identify):
☐ Other (Please Describe):	☐ Internet

Weight History

NAME	DATE

Height:	Current Weight:	What is your desired weight:
How long has it been since you were last on the program?		
What has been your heaviest weight since you were last on the program?		
Did you make it to your desired weight when you were last on the program? ☐Yes ☐No		
If not, why do you feel you were unsuccessful?		
What is the biggest struggle you face in trying to lose & maintain your weight?		
Are any members of your household overweight? ☐Yes ☐No If yes, please list relation and details...		

What is your motivation for returning to our weight loss & wellness program?
Check all that apply.

- ☐ Don't like the way I look
- ☐ More energy
- ☐ Better work opportunities
- ☐ More mobility
- ☐ Attend a wedding/graduation
- ☐ Reduce Pain
- ☐ Perform better
- ☐ Clothes don't fit anymore
- ☐ Improve health
- ☐ Feel better
- ☐ Want to wear smaller sizes
- ☐ Detoxify the body
- ☐ Look better
- ☐ Live longer
- ☐ Increase self confidence
- ☐ Lower blood pressure
- ☐ Look & feel younger
- ☐ Control blood sugar levels
- ☐ Reduce medications
- ☐ other (please describe):

Since last being on our program, have you tried to lose weight on another weight loss program.

Name of Program	Results?	Why this program fell short of your expectations...
☐ Weight Watchers		
☐ Jenny Craig		
☐ Slim Fast		
☐ Atkins		
☐ South Beach		
☐ L A Weight Loss		
☐ Nutri System		
☐ Lindora		
☐ Other		

Have you been exercising? If so, how often do you exercise?

☐ Never ☐ Rarely ☐ Daily ☐ 4-5 times a week ☐ 2-3 times weekly ☐ once a week

What is your exercise routine?
Check all that apply.

- ☐ Walking
- ☐ Swimming
- ☐ Dancing
- ☐ Aerobics
- ☐ Pilates
- ☐ Stairmaster
- ☐ other (please describe):
- ☐ Bicycling
- ☐ Yoga
- ☐ Sports (basketball, tennis, etc.)
- ☐ Strength training
- ☐ Elliptical
- ☐ Treadmill / Jogging

Medical History

Family History (If blood relative has suffered the following, please indicate relationship.)			
Heart Attack		Arthritis	
Cancer		Diabetes	
Hypertension		Obesity	
Stroke		Glaucoma	
Epilepsy		Other	

Have you ever been hospitalized? If yes, when and why?	
Year	**Illness or Operation**

Medications (Please list the medications you are currently taking, and as needed.)			
Medication	**Dosage**	**How Often**	**Reason**

Allergies (Please list any medications or food that you are allergic to.)

Medical History								
Yes	**No**		**Yes**	**No**		**Yes**	**No**	
		Loss of hearing			Hemorrhoids			Anemia
		Ringing in ears			Hernia			Immune disorders
		Ear infections			Gall bladder			Alcohol abuse
		Bad vision			Sudden weight loss			Drug abuse
		Glaucoma			Liver disease			Hypertension
		Nose bleeds			Back pain			Heart disease
		Sinus trouble			Joint pain			Thyroid disease
		Sore throat			Broken bones			Cancer
		Allergies			Dizzy spells			Diabetes
		Hoarseness			Fainting spells			Stroke
		Pneumonia			Memory loss			Osteoporosis
		Bronchitis			Insomnia			GERD
		Asthma			Nervousness			Rashes
		Short of breath			Depression			Chicken pox
		Tuberculosis			Phobias			Mumps/measles
		Heart murmur			Manic depressive			Polio
		Palpitations			Anxiety			Are you pregnant?
		Irregular pulse			Schizophrenia			Could you be Pregnant?
		Swollen ankles			Bulimia			Are you breast feeding?
		Chest pain			Anorexia			Other:
		Loss of appetite			Other eating disorders			
		Indigestion			Frequent urination			
		Stomach ulcers			Kidney disease			
		Diarrhea			Prostate disease			
		Constipation			Headaches			
		Bloody/tarry stools			Fatigue			

Supplements (Please list the supplements you are currently taking, i.e. vitamins, fish oil, etc...)			
Supplement & Brand Name	**Dosage**	**How Often**	**Reason**

Wellness Goals

Which of the following supplements, or products, would you like to incorporate into your wellness Plan?
Check all that apply.

- ☐ Cardiovascular System
- ☐ Joints
- ☐ Bones
- ☐ Prostate
- ☐ Cognitive System (Mind)
- ☐ Weight Loss
- ☐ Beauty/Hair/Skin
- ☐ Immune System
- ☐ Depression
- ☐ Digestive System
- ☐ Sexual Activity
- ☐ Detoxifying the body
- ☐ Hair Loss
- ☐ Menopause
- ☐ Hormone Therapy
- ☐ Weight Maintenance
- ☐ Health Related Foods
- ☐ DNA Testing
- ☐ Anti-Aging
- ☐ Testosterone Levels
- ☐ other (please describe):

Do you feel like your health is improving or declining?

If you could take steps to improve your health for the long term, would you? ☐Yes ☐No

What is your #1 health concern?

What changes to your current health are the least important to you?

If you could change one thing today about your weight or wellness what would it be?

Do you have others in your family who have wellness concerns as well? ☐Yes ☐No
If yes, please list relation and details...