



Dear Patient,

Hello! Congratulations on making this first step in achieving a healthier you! Enclosed is some paperwork that you will need to fill out. It is helpful if you can do it before your appointment and bring it with you. The more detailed you are with the history form, the easier it is for me to get to know you and leave us plenty of time to talk during our visit. If possible, please bring a copy of any recent lab work you may have had in the previous 1-2 years.

Please bring your insurance card and picture ID with you for billing purposes. Please plan to **arrive 15" early** for your appointment so we may take your additional insurance information, any co-pay you may have and to check your vital signs. Initial consultations are 1 hour and follow up visits are 30 minutes. If for some reason you are unable to make your scheduled appointment time, please call the office 24 hours prior.

Please note if your insurance requires a referral from your doctor (some HMO plans etc.), your doctors office should process this referral for you. They may fax it to me at (303) 223-3288.

If your insurance company does not require that you have a doctors referral to see a specialist (most PPO, POS plans etc.) and you are going to be seen for weight management, please call your insurance company to find out if evaluation and treatment for "overweight or obesity" or "medical nutrition therapy" are covered benefits under your plan. We do have discounted 'cash pay' pricing we can give you more information on if your insurance plan will not cover your visit.

We have moved into a brand new office space near Leetsdale Dr. and Monaco St.. The address is 925 S. Niagara St. Suite 370 in Denver. It's a wonderful facility with a full gym and room for us grow our program to better support you in your weight loss journey!

Sincerely,
Rebecca M. Andrick, D.O.



Rebecca M. Andrick, D.O.



925 S. Niagara St. Suite 370 Denver, CO 80224 (303) 321-2383

REVIEW THIS FORM THOROUGHLY; COMPLETE ANY MISSING INFORMATION; SIGN THE FORM; AND RETURN IT TO THE RECEPTIONIST -- THANK YOU

Name of Patient _____
Street Address: _____
City State Zip _____

Account #: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Email: _____

Date of Birth: _____
Social Security #: _____

Marital Status: _____
Sex: M F

Employer: _____
Street Address _____
City, State and Zip _____

RESPONSIBLE/INSURED PERSON INFORMATION

Name: _____
Street Address: _____
City, State and Zip _____
Employer: _____
Spouse Employer: _____

PRIMARY HEALTH INSURANCE

SECONDARY HEALTH INSURANCE

Insurance Name: _____
Group Name/Number: _____
Policy Number: _____
Policyholder Name: _____
Relationship: _____ 1=self 2=Spouse 3=Dependent
Copayment: _____
Referred by: _____

_____ 1=self 2=Spouse 3=Dependent

EMERGENCY CONTACT INFORMATION

Name: _____ Phone: _____

I authorize payment directly to Potomac Square Family Medicine and authorize the release of medical information necessary to process insurance claims. I voluntarily consent to treatment for myself and/or dependents.

Except under certain contractual arrangements; Medicare or Medicaid; and some participating health insurance plans, I will be responsible for the full amount of the charges at the time of service.

Signature of Patient _____
Responsible Person _____ Date: _____

♥RATE YOUR PLATE♥

Think about the way you usually eat. For each food topic, put a check mark in column A, B or C.

TOPIC	A	B	C
1. RED MEAT* <i>beef, hamburger, pork, lamb, veal</i>	<input type="checkbox"/> Usually eat: three times a week or more	<input type="checkbox"/> Usually eat: twice a week	<input type="checkbox"/> Usually eat: once a week or less
2. RED MEAT CHOICES* <i>beef, pork, lamb, veal</i>	<input type="checkbox"/> Usually eat: high-fat cuts, such as ribs, brisket, T-bone steak, prime rib, sausage	<input type="checkbox"/> Sometimes eat: high-fat cuts, such as ribs, brisket, T-bone steak, prime rib, sausage	<input type="checkbox"/> Usually eat: lean beef cuts such as round, loin, flank; lean pork and lamb cuts such as loin and leg; and veal Or, I rarely eat meat
3. GROUND MEAT, BURGERS*	<input type="checkbox"/> Usually eat: regular, chuck or lean ground beef with more than 15% fat	<input type="checkbox"/> Usually eat: ground sirloin or round, ground turkey, or ground beef with 10-15% fat.	<input type="checkbox"/> Usually eat: ground turkey breast or vegetable patties like Boca™ or Garden burgers™ Or, I rarely eat ground meat or burgers
4. CHICKEN, TURKEY, ETC.*	<input type="checkbox"/> Usually eat: chicken, turkey, and other poultry with skin	<input type="checkbox"/> Sometimes eat: chicken, turkey, and other poultry with skin	<input type="checkbox"/> Usually eat: chicken, turkey, and other poultry without skin
5. FISH*	<input type="checkbox"/> Usually eat: fish less than once a week	<input type="checkbox"/> Usually eat: fish once a week	<input type="checkbox"/> Usually eat: fish twice a week or more
6. CHICKEN AND FISH CHOICES*	<input type="checkbox"/> Usually eat: fried chicken and/or fried fish and shellfish	<input type="checkbox"/> Sometimes eat: fried chicken and/or fried fish and shellfish	<input type="checkbox"/> Usually eat: chicken and fish that is baked, broiled, grilled, poached, roasted, etc.
7. COLD CUTS, HOT DOGS, BREAKFAST MEATS*	<input type="checkbox"/> Usually/often eat: salami, bologna, other cold cuts, hot dogs, bacon, sausage	<input type="checkbox"/> Sometimes eat: salami, bologna, other cold cuts, hot dogs, bacon, sausage	<input type="checkbox"/> Usually eat: roast beef, turkey breast, ham, or low-fat cold cuts, low-fat hot dogs, low fat bacon/sausage Or, I rarely eat processed meats
8. SERVING SIZES OF MEATS (COOKED)*	<input type="checkbox"/> Usually eat: large portions (7 oz. or more)	<input type="checkbox"/> Usually eat: medium portions (4-6 oz.)	<input type="checkbox"/> Usually eat: small portions (3 oz. or less)
9. MEATLESS MAIN DISHES <i>like all-bean chili, bean burrito, lentil soup, meatless spaghetti sauce</i>	<input type="checkbox"/> Rarely eat: meatless main dishes	<input type="checkbox"/> Usually eat: meatless main dishes less than twice a week	<input type="checkbox"/> Usually eat: meatless main dishes twice a week or more
10. EATING OUT <i>in restaurants or getting take out food</i>	<input type="checkbox"/> Usually eat out or get take-out food twice a week or more	<input type="checkbox"/> Usually eat out or get take-out food once a week	<input type="checkbox"/> Usually eat out or get take-out food less than once a week OR Usually eat low-fat restaurant meals
11. EGG YOLKS*	<input type="checkbox"/> Usually eat: 6 or more egg yolks a week	<input type="checkbox"/> Usually eat: 4-5 egg yolks a week	<input type="checkbox"/> Usually eat: 3 egg yolks or less a week Or, I usually eat cholesterol-free egg substitutes
12. MILK*	<input type="checkbox"/> Usually eat: whole milk or cream	<input type="checkbox"/> Usually eat: 2% reduced-fat milk	<input type="checkbox"/> Usually eat: 1% low-fat or skim milk
13. CHEESE* <i>include cheese on pizza, sandwiches, snacks & in mixed dishes</i>	<input type="checkbox"/> Usually eat: regular cheese, such as cheddar, Swiss, and American	<input type="checkbox"/> Sometimes eat: regular cheese, such as cheddar, Swiss, and American	<input type="checkbox"/> Usually eat: reduced-fat or part-skim cheese Or, I rarely eat cheese
14. FROZEN DESSERTS <i>ice cream, etc.</i>	<input type="checkbox"/> Usually eat: regular ice cream, ice cream bars/sandwiches	<input type="checkbox"/> Sometimes eat: regular ice cream, ice cream bars/sandwiches	<input type="checkbox"/> Usually eat: sherbet, sorbet, low-fat frozen yogurt or icecream Or, I rarely eat frozen desserts
15. COOKING METHOD	<input type="checkbox"/> Usually add: oil, butter, or margarine to the pan	<input type="checkbox"/> Sometimes add: oil, butter, or margarine to the pan	<input type="checkbox"/> Usually: broil, bake, or steam without fats or oils or use cooking sprays (Pam™)

If you are a vegetarian, check column C for these () topics.

16. COOKING FATS & OILS <i>Choices for cooking and baking</i>	<input type="checkbox"/> Usually use: butter, stick margarine, shortening (i.e. Crisco™), bacon drippings, and/or lard.	<input type="checkbox"/> Usually use: liquid or tub margarine for cooking or baking.	<input type="checkbox"/> Usually use: oils such as olive, corn, and Canola for cooking Or, cook without fat/oils
17. FRIED FOODS <i>like French fries, egg rolls, etc.</i>	<input type="checkbox"/> Often eat: fried foods	<input type="checkbox"/> Sometimes eat: fried foods	<input type="checkbox"/> Rarely eat: fried foods
18. SPREADS <i>Added at the table</i>	<input type="checkbox"/> Usually put: butter or stick margarine on bread, potatoes, vegetables, etc.	<input type="checkbox"/> Usually put: liquid or regular tub margarine on bread, potatoes, vegetables, etc.	<input type="checkbox"/> Usually put: “light” tub margarine on bread, potatoes, vegetables Or, I eat them plain
19. SALAD DRESSING & MAYONNAISE	<input type="checkbox"/> Usually use: regular salad dressing or mayonnaise	<input type="checkbox"/> Sometimes use: regular salad dressing or mayonnaise	<input type="checkbox"/> Usually use: light or fat-free salad dressing and mayonnaise
20. SNACKS	<input type="checkbox"/> Usually/often eat: regular chips, crackers, and nuts	<input type="checkbox"/> Sometimes eat: regular chips, crackers, and nuts	<input type="checkbox"/> Usually eat: fruit, pretzels, low-fat crackers and baked chips
21. DESSERTS & SWEETS	<input type="checkbox"/> Usually/often eat: donuts, cookies, cake, pie, pastry or chocolate	<input type="checkbox"/> Sometimes eat: donuts, cookies, cake, pie, pastry, or chocolate	<input type="checkbox"/> Usually eat: fruit, angel food cake, low-fat or fat-free desserts and sweets
22. GRAINS <i>breads, cereal, rice, pasta</i>	<input type="checkbox"/> Usually eat: white breads; white rice; low fiber cereals like corn flakes, Rice Krispies™, etc	<input type="checkbox"/> Sometimes eat: white breads; white rice; low fiber cereals like corn flakes, Rice Krispies™, etc	<input type="checkbox"/> Usually eat: whole grain breads; brown rice; whole grain cereals like oatmeal, bran cereals, Wheaties™, etc.
23. FRUITS & VEGETABLES <i>(1 serving = 1/2 cup or 1 piece of fruit)</i>	<input type="checkbox"/> Usually eat: 1 serving or less a day	<input type="checkbox"/> Usually eat: 2-4 servings a day	<input type="checkbox"/> Usually eat: 5 or more servings a day

Find your Rate Your Plate score:

Total checks in column A = _____ x 1 = _____

Total checks in column B = _____ x 2 = _____

Total checks in column C = _____ x 3 = _____

TOTAL _____

What does your score mean?

If your score is:

23-38 There are many ways you can make your eating habits healthier.

39-54 There are some ways you can make your eating habits healthier.

55-69 You are making many healthy choices.

What's Next?

Look back at your Rate Your Plate. Do you have any answers in Column C? If you do, great! You are already making some heart healthy choices.

Can you improve? Look at your answers in Columns A and B. Where you checked Column A, can you start eating more like Column B? Over time, move toward Column C.

Set goals. Write down eating changes you are ready to make now.

Goal 1: _____

Goal 2: _____

Goal 3: _____

Begin today. Make changes a little at a time. Let your new way of eating become a healthy habit.

If you are a vegetarian, check column C for these () topics.



Dr. Rebecca Andrick (303) 321-2383 randrick530@pol.net

Date: _____

Patient Name: _____

Birth date: _____ Age: _____

Primary Care Provider: _____

ALLERGIES: _____

History of Present Condition:

Please describe how and when your weight or nutrition problem became an issue for you?

Previous Weight loss attempts:

Diet type tried	Dates	Results? Short and Long term

What is your lowest weight and how old were you? _____ Maximum? _____

What do you think is a realistic goal weight for you? _____

Reason? _____

Current Dietary Habits

Typical Meal	Breakfast	Lunch	Dinner	Snacks/Desserts
Foods				
When/Where?				
With whom?				

How many times per week are you going out to eat? _____

How often do you eat Fast Food per week? (ie: McDonald's, Taco Bell) _____

What will you order? _____

Which "sit down" restaurants do you frequent? _____

How many high sugar beverages do you drink per day? (i.e. soda, juice, energy drinks) _____
 Who plans meals? _____ Shops? _____ Cooks? _____
 Your favorite foods? _____
 Food dislikes? _____

Current Physical Activities

Activity?			
Time spent?			
Frequency?			

What types of physical activities do you enjoy? _____
 When does fitting exercise into your life work best? _____
 Where do you like to exercise? _____

Social History

Marital Status? _____ Partner's Name/ Age/Overweight? _____
 How many children or other persons are living with you? _____

What is your occupation? _____
 Work Schedule: _____ Commute time? _____
 Activity level at work? sedentary mild activity moderately active physically demanding

Do you smoke? How much for how long? _____
 How many how many alcoholic beverages do you drink per week? _____
 If so, what do you like to drink and how much per serving? _____
 Do you use any Recreational drugs? What type? _____

What was your family culture growing up like with regards to food?
 Did your family sit and eat together? _____
 Were you required to "clean your plate"? _____
 Did you ever experience not having enough food to eat? _____
 Were you given food as a reward for good behavior or achievements? _____
 Do you use food now to relieve stress or for "comfort"? _____

Past Medical History (Please circle all that apply)

Diabetes High Blood Pressure Abnormal Cholesterol Liver Disease Eating Disorder
 Heart disease Sleep Apnea PCOS (polycystic ovarian disease) Gout Depression

Other Medical problems: _____

Women: Age of onset of periods? _____ Are you having periods now? _____
 If yes: Are your periods regular and monthly or irregular? _____
 How heavy are your periods and how long do they last? _____
 Have you experienced difficulties becoming pregnant? _____

Past Surgical History

Surgery Type	Date
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Medications

Please include all prescription medications, vitamins and supplements and over the counter drugs.

Name	Dosage	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Family History

Relative	Age	Living	Medical Problems? Are they Overweight?
Mother			
Father			
Sibling (sis or brother?)			
Sibling			
Sibling			
Mother's Mother (GM)			
Mother's Father (GF)			
Father's Mother (GM)			
Father's Father (GF)			
Children			
Children			
Children			
Family with early onset of heart disease/ cancer			

Review of Systems (circle all that apply)

of Sleep hours/night _____ Bedtime? _____ Wake time? _____
Snoring Apnea (waking due to stopping breathing)
Fever Chills Night sweats Hot Flashes Fatigue Weakness
Neck or jaw swelling Chronic nasal congestion Difficulty swallowing
Chest pain (if yes, with or without activity?) Shortness of breath with activity
Palpitations Jaw, shoulder or arm pain with activity?
Wheezing of cough with physical activity? Chronic cough Shortness of breath at rest
Heartburn Constipation Diarrhea Blood in Stools Excess Gas
Nausea Vomiting Abdominal Pain
Excessive thirst Excessive Water intake Hair loss Intolerance of heat or cold
Frequent urination Large volumes of urine Blood in urine Waking to Urinate
Men only: Problems with Erections
Numbness or Tingling in Extremities Burning or Pain in Extremities Headaches
Joint Pain (Which? _____) Muscle Pain (Where? _____)
Swelling in extremities (Where? _____)
Feeling sad Feeling anxious Excessive Stress Binging on Food
Sleep Disturbed Insomnia Guilt or Shame After Eating Hiding Food
Acne Skin Rash Dark Skin lesions in folds of skin
Women only: Excess facial hair Nipple hair Lower Abdominal hair Nipple Discharge

Preventative Medical Care Status

Date of most recent blood work? Where done? _____

Test/Exam	Date	NI.	Abn.	Results
Physical				
Lipid Profile				Tot. LDL HDL Trig.
TSH/Thyroid test				
Stool test for blood				
Colon Screening?				
Pap Smear				
Mammogram				
PSA				
EKG				
Treadmill				
Hgb A1C				