OClinic
OVERCOME OBESITY

OFFICE USE ONLY GENIE ID:				
Date	**Weight (kg)**	**Height (cms)**	**BMI**	**Excess**
Target weight	**Max weight**	**Insurance**	**Super release**	**Procedure**

NEW PATIENT INFORMATION SHEET

All fees are requested at the time of consultation unless paid prior to consultation.

Title:_____First Name:_____Surname:_____
(as it appears on your Medicare and Health Insurance card)

Prefer to be called: _____Marital Status: _____

Address :_____

Suburb:_____ State:_____ Post Code:_____

Date of Birth:_____Age: _____ Sex: Male / Female (Please circle)

Home Phone:_____Work Phone:_____Mobile:_____

Email address: _____

Medicare No:_____Reference No. _____ Card Expiry:_____

Do you have private health insurance? Y / N

Private Health Fund:_____Membership No._____

Do you intend to release your superannuation? Y / N

Indigenous status: Aboriginal origin Y / N TSI origin Y / N

Dept Veteran Affairs No:_____Occupation:_____

Referring Dr:_____Practice Name and Address: _____

_____Phone:_____

Are there any other health professionals involved in your care? If so, please provide details:
_____

_____

Correspondence will be sent to your treating doctors/practitioners. Do you agree to this? Y / N

Next of Kin/Emergency Contact:_____ Phone:_____

Relationship to you_____

PERSONAL MEDICAL HISTORY

Weight related Medical Conditions: Do you have any of the following conditions?

High blood pressure Y / N	High cholesterol Y / N
Angina (cardiac chest pain) Y / N	Infertility Y / N
Weight bearing joint pain Y / N If yes, which joints? _____	Polycystic Ovary Syndrome Y / N
Fatty Liver Y / N	Do you have insulin resistance? Y / N
Type 2 Diabetes Y / N If yes, how long have you had Diabetes? _____ What treatment is used to control your Diabetes? Tablet controlled Y / N Diet controlled Y / N Is insulin required Y / N	
Gall bladder disease or gallstones Y / N / unsure	Chronic heartburn or reflux Y / N
Do you have a hiatus hernia? Y / N / unsure	
Have you been diagnosed with Depression? Y / N Have you noticed improvement when you lose weight? Y/ N	
Do you have sleep apnoea? Y / N / unsure Has this been confirmed with a sleep study? Y / N Do you use CPAP? Y / N	

Past Abdominal Surgery Please indicate if done laparoscopically (keyhole) or open

	Details
Previous bariatric surgery? Y / N	
Gallbladder removal? Y / N	
Removal of appendix? Y / N	
Colon Surgery? Y / N	
Gynaecological surgery? Y / N	
Any other abdominal surgery? e.g. emergency surgery, injury	

Other medical conditions

	Details
Do you have any cardiac (heart) problems? Y / N If yes, who is your heart specialist?	
Do you have any respiratory (breathing) problems, eg asthma Y / N	
Have you ever had problems with anaesthetics? Y / N	
Have you ever had a blood clot or bleeding problems? Y / N	

	Details
Do you have any other medical conditions or problems? Y / N Please provide details of any other medical conditions, including any mental health issues	
Do you have any allergies? Please provide details of any allergies	
Do you smoke? Y / N How many cigarettes do you smoke a day? If you have stopped smoking, when did you stop?	

Current Medications – Please list below	
Name of drug	
1.	2.
3.	4.
5.	6.
7. **Current Nutritional supplements**	8.

FAMILY HISTORY (Blood relatives)

Do you have a family history of any of the following?

Obesity	☐	Which family member/s?
Diabetes	☐	
Heart Disease	☐	
Stroke	☐	
Cancer - Which type?	☐	

WEIGHT LOSS HISTORY

1) How many years have you been struggling with your weight? _____

2) What is your reason/motivation to lose weight? _____

3) How do you feel weight loss surgery can help you? _____

5) What is the most weight (in kg's) you have ever lost? _____

6) What is the heaviest you have ever been? _____

What have you tried in the past to lose weight? (please circle)

Weight Watchers	Tony Ferguson	Lemon detox	Atkins Diet
Pritikin diet	Optifast	Dietitian	Hypnotherapy
Acupuncture	Counselling	Gym membership	Personal trainer
CSIRO diet	Isowhey	Own personal diet	Jenny Craig
Lite 'n' Easy	Sureslim	Fasting (5:2) diet	Duromine
Reductil	Xenical	Other	

Reasons for eating (please circle)

Stress	Boredom	Hunger
Comfort	Binge	

Are you allergic or intolerant to particular foods? Y / N

If yes please list _____

Physical Activity

Do you exercise? Y / N What type of exercise? _____

Amount of exercise per day/ week? _____

How does your weight affect your quality of life?

*Please circle -	(not at all)	(mildly)	(moderately)	(significantly)	(excessively)
Sleep	1	2	3	4	5
Energy	1	2	3	4	5
Perspiration	1	2	3	4	5
Self Esteem	1	2	3	4	5
Confidence	1	2	3	4	5
Relationships	1	2	3	4	5
Occupational limitations	1	2	3	4	5
Urinary Incontinence	1	2	3	4	5
Avoid being photographed	1	2	3	4	5
Avoid social events	1	2	3	4	5
Avoid swimming in public	1	2	3	4	5

Have you attended an information seminar? Y / N If yes, where? _____

Do you have a friend or relative that has had weight loss surgery? Y / N

If yes which type? Gastric band Sleeve Gastrectomy Gastric Bypass Other: _____

How have you gone about researching weight loss surgery? please circle

TV Newspaper/ Magazines Talking to someone who has had surgery

Internet Which site/s? _____

How long have you been seriously thinking about weight loss surgery? _____

How did you find out about the OClinic? _____

INITIAL DIET ASSESSMENT

* Which best describes your **eating pattern**?

Three meals a day — Three meals, plus snacks
Often skipping meals/no pattern — Grazing throughout the day

* In a typical 7-day week, for **breakfast** how many times would you?
Prepare at home____ Eat out/ buy____ Not eat____

* Describe your common **breakfast** meals? (e.g. ½ cup natural muesli + ½ cup full fat milk + banana + slice white toast + butter) _____

* Where do you typically eat **breakfast** (e.g. at the table, in front of TV/computer, in car)? _____

* In a typical 7-day week, for **lunch** how many times would you?
Prepare at home____ Eat out/ buy____ Not eat____

* Describe your common **lunch** meals? (e.g. 2x wholegrain sandwiches with ¼ avocado, tuna + lettuce + low fat yoghurt) _____

* Where do you typically eat **lunch** (e.g. at a table, in front of TV/computer, in car)? _____

* In a typical 7-day week, for **dinner** how many times would you?
Prepare at home____ Eat out/ buy____ Not eat____

* Describe your common **dinner** meals? (e.g. 200g steak + ½ plate of oven fries + small salad + dressing)
_____

* Where do you typically eat **dinner** (e.g. at a table, in front of TV/computer, in car)? _____

* If you **snack/graze,** what do you snack on? (e.g. nuts, fruit, chocolate, chips, crackers and cheese, sweet biscuits) _____

How often do you eat **potato chips or savory/salty snacks**?
Once a week or less ☐ 2-3 times/ week ☐ 4-6 times/ week ☐ Daily ☐

How often do you eat **chocolate or lollies snacks**?
Once a week or less ☐ 2-3 times/ week ☐ 4-6 times/ week ☐ Daily ☐

How often do you eat **cake, sweet biscuits, muffins or pastries**?
Once a week or less ☐ 2-3 times/ week ☐ 4-6 times/ week ☐ Daily ☐

How often do you eat **fast foods** (e.g. McDonalds, KFC, Hungry Jacks)?
Once a week or less ☐ 2-3 times/ week ☐ 4-6 times/ week ☐ Daily ☐

How many **cups** of the following drinks would you **drink in a day**?

Water	____	Juice/cordial	____
Tea/herbal tea	____	Coffee	____
Diet cordial	____	Milk	____
Diet soft drink	____	Soft drink/ energy drink	____

PSYCHOLOGICAL REVIEW

1. Have you seen or are you seeing a psychologist / psychiatrist? Y / N
2. Have you been prescribed psychological medication? Y / N _____
3. Briefly describe your work situation: what do you do, how content you are you, career/study plans?

_____

_____

4. Briefly describe your current family / support structure: e.g. single, married, supportive / strained relationship, children, grandchildren, social network.

_____

_____

5. Do you eat due to any of the following factors (please circle): Depression, anxiety, stress, boredom, feeling overwhelmed, loss of control, comfort, love of food, reduced self-discipline?

6. When you think about your weight journey are there any situations, emotions or thoughts that have made your journey more challenging?

_____

_____

7. Have you ever had an eating disorder? Y / N _____
8. Do you ever seek privacy when eating? Y / N _____

9. On a scale from 1 to 10 (1 being not very motivated and 10 being extremely motivated) how motivated are to you achieve your weight loss goals following surgery? _____/10_____

10. On a scale from 1 to 10 (1 being not wanting to and 10 wanting to very much) how much do you want to achieve your weight loss goals in combination with surgery? _____/10_____

11. On a scale from 1 to 10 (1 being not often at all and 10 being almost always) how often are you thinking about food? _____/10_____

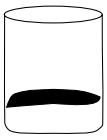
12. Do you have any thoughts in relation to how a psychologist may be able to assist you with ongoing weight loss from an emotional / behavioural / thought perspective?

_____

Australian Government
Department of Veterans' Affairs

Alcohol Screen (AUDIT)

THE RIGHT MIX

Light Beer 425ml 2.9% Alcohol	Full Strength Beer 285ml 4.9% Alcohol	Wine 100ml 12% Alcohol	Fortified Wine 60ml 20% Alcohol	Spirits 30ml 40% Alcohol	Full Strength Can or Stubbie 375ml 4.9% Alcohol
					

The guide above contains examples of one standard drink. A full strength can or stubbie contains *one and a half standard drinks.*

Introduction

Because alcohol use can affect health and interfere with certain medications and treatments, it is important that we ask you some questions about your use of alcohol. Your answers will remain confidential, so please be as accurate as possible. Try to answer the questions in terms of 'standard drinks'. Please ask for clarification if required.

AUDIT Questions Please tick the response that best fits your drinking.

						Score	Sub totals
		Never	*Monthly or less*	*2 - 4 times a month*	*2 - 3 times a week*	*4 or more times a week*		
1.	How often do you have a drink containing alcohol?	☐ ▼ Go to Qs 9 & 10	☐	☐	☐	☐	☐	
		1 or 2	*3 or 4*	*5 or 6*	*7 to 9*	*10 or more*		
2.	How many standard drinks do you have on a typical day when you are drinking?	☐	☐	☐	☐	☐	☐	
		Never	*Less than monthly*	*Monthly*	*Weekly*	*Daily or almost daily*		
3.	How often do you have six or more standard drinks on one occasion ?	☐	☐	☐	☐	☐	☐	☐
4.	How often during the last year have you found that you were not able to stop drinking once you had started?	☐	☐	☐	☐	☐	☐	
5.	How often during the last year have you failed to do what was normally expected of you because of drinking?	☐	☐	☐	☐	☐	☐	
6.	How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	☐	☐	☐	☐	☐	☐	☐
7.	How often during the last year have you had a feeling of guilt or remorse after drinking?	☐	☐	☐	☐	☐	☐	
8.	How often during the last year have you been unable to remember what happened the night before because you had been drinking?	☐	☐	☐	☐	☐	☐	
		No		*Yes, but not in the last year*		*Yes, during the last year*		
9.	Have you or someone else been injured because of your drinking?	☐		☐		☐	☐	
10.	Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	☐		☐		☐	☐	☐
							TOTAL	

Supplementary Questions	*No*	*Probably Not*	*Unsure*	*Possibly*	*Definitely*
Do you think you presently have a problem with drinking?	☐	☐	☐	☐	☐
	Very easy	*Fairly easy*	*Neither difficult nor easy*	*Fairly difficult*	*Very difficult*
In the next 3 months, how difficult would you find it to cut down or stop drinking?	☐	☐	☐	☐	☐

Do you experience any of the following symptoms? Please tick the box provided

1. Eating, in a short period of time (for example, in 2-hours), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances? ☐

2. A sense of lack of control over eating during the episode (for example, a feeling that you cannot stop eating or control what or how much you are eating)? ☐

3. Eating much more rapidly than normal? ☐

4. Eating until feeling uncomfortably full? ☐

5. Eating large amounts of food when not feeling physically hungry? ☐

6. Eating alone because of feeling embarrassed by how much you are eating? ☐

7. Feeling disgusted with yourself, depressed, or very guilty afterwards? ☐

8. Significant distress due to the binge? ☐

9. The binge eating occurs, on average, at least once a week for three months? ☐

10. The binge eating is not associated with the repeated use of inappropriate compensatory behaviour (for example, vomiting, laxatives)? ☐

DASS 21 NAME _____ DATE _____

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all - NEVER

1 Applied to me to some degree, or some of the time - SOMETIMES

2 Applied to me to a considerable degree, or a good part of time - OFTEN

3 Applied to me very much, or most of the time - ALMOST ALWAYS

		N	S	O	AA	FOR OFFICE USE D	A	S
1	I found it hard to wind down	0	1	2	3			
2	I was aware of dryness of my mouth	0	1	2	3			
3	I couldn't seem to experience any positive feeling at all	0	1	2	3			
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3			
5	I found it difficult to work up the initiative to do things	0	1	2	3			
6	I tended to over-react to situations	0	1	2	3			
7	I experienced trembling (eg, in the hands)	0	1	2	3			
8	I felt that I was using a lot of nervous energy	0	1	2	3			
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3			
10	I felt that I had nothing to look forward to	0	1	2	3			
11	I found myself getting agitated	0	1	2	3			
12	I found it difficult to relax	0	1	2	3			
13	I felt down-hearted and blue	0	1	2	3			
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3			
15	I felt I was close to panic	0	1	2	3			
16	I was unable to become enthusiastic about anything	0	1	2	3			
17	I felt I wasn't worth much as a person	0	1	2	3			
18	I felt that I was rather touchy	0	1	2	3			
19	I was aware of the action of my heart in the absence of physicalexertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3			
20	I felt scared without any good reason	0	1	2	3			
21	I felt that life was meaningless	0	1	2	3			
					TOTALS			

Psychology Services: Client Consent Form

Counselling Service

As part of providing a holistic program the OClinic will need to collect and record personal information from you that is relevant to your current situation. This information will be a necessary part of the professional counselling service that is provided.

Purpose of collecting and holding information
The information is gathered in order to provide suitable counselling for your presenting issues and to assist with your weight loss. The information is retained in order to document what happens during sessions, and enables the OClinic to provide a relevant and informed assistance and counselling service.

Access to Client Information
At any stage you as a client are entitled to access the information about you kept on file, unless relevant legislation provides otherwise.

Confidentiality
All personal information gathered by the OClinic during the session will remain confidential and secure except where:

1. Failure to disclose the information would place you or another person at serious and imminent risk; or
2. There is an obligation to disclose the information under the *Commission for Children and Young People Act (2000)*; or
3. It is subpoenaed by a court; or
4. It is used in relation to defending the Department in legal proceedings or for obtaining advice in respect of any potential legal proceedings; or
5. De-identified information is used for reporting and statistical purposes; or
6. Information is discussed as part of an approved professional supervision process; or
7. Your prior approval has been obtained to:
    a) provide a written report to another professional or agency (e.g., a GP); or
    b) discuss the material with another person, (e.g., a family member, employer, rehabilitation coordinator); or
8. If disclosure is otherwise required or authorised by law.

All personal information is maintained in a password protected computer program which is solely accessed by the OClinic.

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I, …… … …*(print name)*, have read and understood the above Consent Form. I agree to these conditions under the counselling service provided by the OClinic.

Signature: ……
(Client)

Date: ……

PRIVACY INFORMATION AND CONSENT FORM

The Privacy Act 1988 gives you certain rights in relation to information that you give to this medical practice. We need your consent to collect personal information about you. The fact that you have come here implies that you consent to us knowing about your health situation either for a particular event or generally. This form explains what your rights are over the use we make of the information and how we may disclose it to other medical service providers.

Good medical care requires full patient disclosure and knowledge of a patient 's health information by all members of a medical team. To ensure quality and continuity of patient care, a patient's health information has to be shared with other health care providers from time to time.

Please carefully read the following information about privacy issues, then sign this form where indicated below. It will go on your file and you may examine it at any time.

The main reason we collect information from you is so we can assess, diagnose and treat your illness properly. We will also use the information you provide in the following ways:

- Administration of this practice.
- Billing, including compliance with Department of Human Services - Medicare requirements.
- Disclosure to others involved in your health care, including doctors and specialists outside this practice who may become involved in treating you. This may occur through referral to other doctors, or for medical tests, and in the reports or results returned to us following the referrals.
- Disclosure to others for medical defence purposes if necessary.

PATIENT'S ACKNOWLEDGEMENT

I have read this form and understand why collecting information about me is necessary. I am also aware that this practice has a privacy policy on handling patient information.

While I understand that I am not obliged to provide any information requested of me, I also understand that failure to provide this medical practice with all the information it needs may restrict the practice's ability to provide the quality of health care and treatment that I want.

I am aware that I have the right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure about which I notify this practice now or at any future time.

I acknowledge that I have read this form before signing it and that a member of the staff of this practice has at my request clarified any aspects of it that I did not at first understand.

Signed: (patient) _____ **Date:** _____

NAME (please print): _____

PLEASE USE THIS PAGE IF YOU HAVE ANY FURTHER DETAILS OR INFORMATION :