NEW DIRECTIONS

5501 Pinnacle Point Drive
Rogers, Arkansas 72758
479-268-6404

## Enrollment Application

## For The New Directions VLCD and New Directions LCD

**CONFIDENTIAL**

Date: _____

**NOTE: This form must be completed before you can be enrolled in the New Direction system. Please answer every question. Please print clearly.**

Name (Last - First - Initial)

Address (Street - City - State - Zip) | Best Daytime Phone Number ( ) - -

Occupation | Name of Employer | Alternate Phone Number (if applicable) ( ) - -

Birth Date (Month - Date - Year) / /

Circle Marital Status: Single Married Divorced Separated Widowed

Sex (Circle): Male Female

Circle Level of Highest Education Completed

Grade School High School Some College College Grad Grad School Some Tech School Tech School Grad

Emergency Contact: (Name - Address (Street, City, State, Zip) - Phone Number)

Have you been treated at this health care facility before? Circle one: Yes No

### WEIGHT HISTORY

Current weight How long have you been at your current weight?

Were you normal weight or overweight as a child?

How much did you weigh when you graduated high school?

Have you had a gradual weight gain or sudden weight gain?

What was your highest adult weight?

What was your lowest most maintained adult weight?

What is your goal weight? When did you last weigh this amount?

Present height? (feet, inches)

What diets have you done that have worked?

What diets have you done that did not work?

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## MEDICAL HISTORY

**Physician to receive your progress reports:**

Name: Office Address: Phone:

When was your last complete physical exam? Month: Year:

**FOR YOUR SAFETY, please give a COMPLETE/DETAILED list of ALL your medications.**
**Attach additional sheet/sheets if necessary.**
**It is VERY important that you inform us of ANY changes in your medications at ANY time.**

| Diagnosis | Medication | Dosage | Frequency |
|---|---|---|---|
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**Please list any/all over-the-counter medications/vitamins/supplements you currently take including dosage and frequency.**

**Surgeries/Hospitalizations:**

| Event | Diagnosis/Reason | Date Performed |
|---|---|---|
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## Please check if you have any of the following:

____ Heart attack within the last 3 months

____ Stroke within the last 3 months

____ Insulin-dependant diabetes (juvenile-onset diabetes)

____ Liver disease requiring protein restriction

____ Pregnant or planning to become pregnant within 6 months

____ Kidney disease requiring protein restriction

____ Recent treatment for cancer (please describe)

____ Peptic ulcer disease that is not resolved or under good medical control

____ Recent onset of inflammatory bowel disease

____ Non-insulin dependant diabetes

____ Recent uric acid kidney stone or untreated hyperuricemia

**Are you allergic to:**

Cocoa? ____ Yes ____ No

Milk protein? ____ Yes ____ No

Corn? ____ Yes ____ No

Soy? ____ Yes ____ No

Eggs? ____ Yes ____ No

Other food? (describe)

**Are you sensitive to or do you have a problem with:**

Aspartame (Nutrasweet)? ____ Yes ____ No

Monosodium glutsmate (MSG)? ____ Yes ____ No

Lactose? ____ Yes ____ No

(unable to drink milk but able to eat cheese and yogurt) ____ Yes ____ No

## PLEASE GIVE A COMPLETE LIST OF ANY ALLERGIES TO MEDICATIONS.

_____

_____

_____

_____

Do you smoke? ____ Yes ____ No

**Number of pregnancies:** _____

**Weight gain with pregnancies:** _____

**Date of last menstrual period:** _____

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**FAMILY HISTORY**

## Please check if any blood relative has had any of the following:

| Condition | Mother | Father | Sibling | Grandparent - Please note whether maternal or paternal. | |
|---|---|---|---|---|---|
| Anemia | | | | | |
| Leukemia | | | | | |
| Arthritis | | | | | |
| Chronic Lung Disease | | | | | |
| High Blood Pressure | | | | | |
| Kidney Deisease | | | | | |
| Asthma | | | | | |
| Severe Allergies | | | | | |
| Mental Illness | | | | | |
| Convulsions/Seizures | | | | | |
| Cardiovascular Disease | | | | | |
| Migraines | | | | | |
| Diabetes 1 or 2 | | | | | |
| Gout | | | | | |
| Obesity | | | | | |
| Thyroid Trouble | | | | | |
| Peptic Ulcer | | | | | |
| Irritable Bowel / IBS | | | | | |
| Cancer | | | | | |
| Depression | | | | | |
| Suicide | | | | | |
| Gallbladder Disease | | | | | |
| Alcoholism | | | | | |