Program Enrollment
For The New Direction VLCD and New Direction LCD

CONFIDENTIAL

DATE: _____

Email:_____*(preferred method of contact)*

Name (Last-First-Initial)	Email
Address (Street-City-State-Zip)	Phone No.

Birth date (Month-Day-Year)	Marital Status	SEX
	Single Married Divorced Separated Widowed	MALE FEMALE

Circle Level of Highest Education Completed

Grade School High School College

Emergency Contact

Name (Last-First-Initial)	Address (Street-City-State-Zip)	Phone No.

Have you been treated at this health care facility before? o Yes o No

WEIGHT HISTORY

Patient weight (lbs)	Indicate ages during which you were overweight
Present height (feet, inches)	o Childhood (Age 2-11 yrs) o Age 20-29 yrs
What is your goal weight?	o Adolescence (Age 12-19 yrs) o Age 30-40 yrs
When did you last weight this amount?	o Over 40 yrs

How much weight do you expect to lose during this program? _____ lbs.

Which weight loss methods have you tried in the past? Please be as specific as possible (eg. NutriSystem, Jenny Craig, Starvation, Protein Formula, Medications, Spa, Hypnosis, Weight Watchers, Psychotherapy, Etc.)

Weight loss method	How long was loss maintained?	Why did you stop treatment?	Problems during treatment
Sample: Stillman Diet	*2 months*	*Desired other foods*	*Dizziness*

Which weight loss method do you consider you're most successful?

What accounted for that success?

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MEDICAL HISTORY

Primary Care Physician: **Referring Physician:**

Name/Phone Name/Phone

When was your most recent complete physical exam? Month: Year:

CURRENT MEDICATIONS

Name	Dosage	How Often

PAST MEDICAL HISTORY (Please check all that apply)

_____ Heart Disease _____ High Blood Pressure _____ Diabetes _____ Renal/Kidney Disease

_____ Cancer _____ Kidney Stones _____ Heartburn or reflux _____ Inflammatory Bowel Disease

_____ Other (please explain) _____

WOMEN ONLY

_____ Pregnant or planning to become pregnant within 6 months Number of pregnancies _____

Date of most recent menstrual period _____ Weight gain with pregnancies _____ lbs

PSYCHOSOCIAL HISTORY

Are you at present undergoing any major lifestyle changes (eg, marriage, divorce, job change, death of someone important to you)? If so, describe:

What other commitments do you that might interfere with your fully participating in the New Direction System?

What benefits do you hope to gain from being in this program other than losing weight?

Who do you feel will be supportive of your weight loss and changes in lifestyle? (circle and name your choices)
Spouse Children Roommate(s) Parent(s) Friend(s) Co-worker(s) Other

Who do you feel may **not** be supportive of your weight loss and changes in lifestyle? (circle and name your choices)
Spouse Children Roommate(s) Parent(s) Friend(s) Co-worker(s) Other

PSYCHOSOCIAL HISTORY (CONT.)

List five reasons you think it is important for you to lose weight. Please number the reasons, with "1" being the most important.

1.

2.

3.

4.

5.

Why did you choose this particular program?

Are you currently in any kind of psychotherapy? o YES o NO
If yes, please specify:

With whom	For what	Date treatment began

Have you been in any kind of psychotherapy in the past? o Yes o No
If yes, please specify:

With whom	For what	Date treatment began	Ending date

Have you ever been hospitalized for psychiatric reasons? If so, please complete the following:

Date of Admission	Length of Stay	Reason for Hospitalization

Have you ever had suicidal thoughts? o Yes o No	Have you ever been severely depressed? o Yes o No o Possibly	Have you ever experienced dramatic mood changes during dieting (especially anxiety or depression)? o Yes o No o Possibly

Have you ever eaten a large amount of food rapidly and felt this eating incident was excessive and out of control (aside from holiday feasts)? o Yes o No

If yes, how often did you do this during the past year? (check one)

- o Less than once a month
- o About once a month
- o A few times a month
- o About once a week
- o About three times a week
- o Daily

Have you ever purged (used self-induced vomiting, laxatives, or diuretics)? o Yes o No

LIFESTYLE AND EATING HABITS

Do you drink alcohol? o Yes o No

If yes, how much?

- o 1 drink a month
- o 1 drink a week
- o More than 1 drink a week
- o 1 drink a day
- o More than 1 drink a day

How often do you exercise?

- o Rarely
- o Occasionally
- o 1-2 times a week
- o 3-4 times a week
- o 5 or more times a week

Has any doctor or other health care professional ever told you not to exercise? o Yes o No

Do you know of any reason why you should not exercise? o Yes o No

If you answered yes to either question, please explain:

How many meals do you typically eat out per week? _____

Are the majority of these meals with family or friends? o Yes o No

Are they usually fast food (eg, McDonald's)? o Yes o No

Usually in cafeteria/restaurant? o Yes o No

LIFESTYLE AND EATING HABITS (CONT.)

Of the following, check all the items that you feel help explain or describe your eating habits:

- o Thinking about food too much of the time
- o Eating high-fat foods
- o Eating too many sweet foods
- o Eating too quickly
- o Uncontrollable binges
- o Eating in reaction to tension and depression
- o Overeating when alone
- o Using food as a reward
- o Eating to take my mind off other problems
- o Not paying attention to what I'm eating
- o Overeating at social events
- o Lack of satisfaction in life
- o Eating in reaction to boredom
- o Other (explain) _____

Are you allergic to

Cocoa?	o Yes	o No
Milk protein?	o Yes	o No
Corn?	o Yes	o No
Soy?	o Yes	o No
Eggs?	o Yes	o No

Other food? (describe) _____

Are you sensitive to or do you have a problem with

Aspartame (Nutrasweet)?	o Yes	o No
Monosodium glutamate (MSG)?	o Yes	o No
Lactose? (unable to drink milk but able to eat cheese and yogurt)	o Yes	o No

Do you smoke? o Yes o No

I certify that the information on this form is true and correct to the best of my knowledge.

Signature _____ Date _____

I give permission for the data provided in this from and obtained in subsequent visits and interviews to be submitted to Robard Corporation, Division of Food Sciences, for the purpose of group evaluation of data. Except for the purpose of matching current and future data, my name will not be used in conjunction with any of the data. I understand that such group evaluation may, from time to time, be used in publications or other materials, but that participant confidentiality will be maintained.

Signature _____ Date _____

FOR ND USE ONLY

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Diet Readiness Behavioral Questionnaire

For each question, circle the answer that best describes how you feel.

Section 1: Goals and Attitudes

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

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

2. 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

3. Consider all outside factors at this time 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 diet?

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

4. Think honestly about how much weight you hope to lose and how quickly you hope to lose it. Figuring a weight loss of 1 to 2 pounds per week, how realistic is your expectation?

1	2	3	4	5
Very Unrealistic	Somewhat Unrealistic	Moderately Unrealistic	Somewhat Realistic	Very Realistic

5. While dieting, do you fantasize about eating a lot of your favorite foods?

1	2	3	4	5
Always	Frequently	Occasionally	Rarely	Never

6. While dieting, do you feel deprived, angry and/or upset?

1	2	3	4	5
Always	Frequently	Occasionally	Rarely	Never

Section 1 TOTAL SCORE _____

Section 2: Hunger and Eating Cues

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

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

8. How often do you eat because of physical hunger?

1	2	3	4	5
Always	Frequently	Occasionally	Rarely	Never

9. Do you have trouble controlling your eating when your favorite foods are around the house?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

Section 2 TOTAL SCORE _____

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Section 3: Control Over Eating

If the following situations occurred while you were on a diet, would you be likely to eat **more** or **less** immediately afterward and for the rest of the day?

10. Although you planned on skipping lunch, a friend talks you into going out for a midday meal.

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

11. You "break" your diet by eating a fattening, "forbidden" food.

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

12. You have been following your diet 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 _____

Section 4: Binge Eating and Purging

13. 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

14. If you answered yes to #13, how often have you engaged in this behavior during the last year?

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

15. Have you ever purged (used laxatives, diuretics or induced vomiting) to control your weight?

5	0
Yes	No

16. If you answered yes to #15 above, how often have you engaged in this behavior during the last year?

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 _____

Section 5: Emotional Eating

17. 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

18. 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

19. 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

Section 6: Exercise Patterns and Attitudes

20. How often do you exercise?

1	2	3	4	5
Never	Rarely	Occasionally	Somewhat	Frequently

21. 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

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