



Welcome!

This could be the start of a very exciting time in your life. You might be wondering how to lose the excessive weight and you might be wondering “why do I need to?” If you are like most Americans, you weigh more now than you have your entire life. It’s time to do something about this problem.

If you have been to a physician about your weight, chances are you have been told to just quit eating so much, push away from the table sooner, or exercise more. You and I know that there is a lot more to weight management than those simple rules.

You must know that you are not unique in your situation. Many people have this problem. In fact, 66% of all Americans are either overweight or obese as well as 17% of all children. Most do not have the necessary knowledge and tools to succeed.

Obesity is on the rise. It is now the leading cause of preventable death in America, just pushing ahead of smoking. The World Health Organization states that 300 million worldwide are obese with a billion people overweight. The statistics are very clear in that obesity and overweight are a leading cause of cardiovascular disease, Type II diabetes, arthritis, depression, cancer, and hypertension, to name only a small portion of the linked diseases.

Here at our medical weight loss program, we have the knowledge and the tools to virtually guarantee you successful weight reduction and permanent weight maintenance. In order to do a job, you must have the right tools. How many times has it been successful to turn a screw with a hammer? Does it not work better when you use a screwdriver? Likewise, if you don’t have the tools to achieve permanent weight reduction, how can you hope to be successful in the long term? You will receive the correct tools in my program.

Our program is designed around an 8 week course that gives you the knowledge and the tools to understand your body and its natural tendencies for weight gain. Remember, we are essentially hunters and gatherers. I am going to help you to understand your metabolism and your God-given genetics. It is very important to understand that these genetics are wonderful and incredibly beneficial because they were designed to save your life in the event of starvation. However, in the land of plenty, these genetics can ‘backfire’ on us.

When you are presented with some of these complex mechanics in a very organized and understandable fashion, you will increase your long term weight loss reduction and maintenance success. The cravings and the urges, the triggers and the reflex association, as well as the linking of eating and food become recognizable and manageable.

I know how this works. You see, I too experienced an 80 pound weight gain. Keep in mind; people do not willingly change because ‘life is good’. We always initiate change and for me, that occurred many years ago. I understand what it is like to be 80 pounds overweight, fatigued, emotionally and physically exhausted, and eating out of control for comfort and entertainment. My program has developed over the past several years in response to my own needs and then adjusted and improved based on the needs of thousands of patients.

You are not alone. My team and I are committed to your long term success. Come visit me at our weekly consult and let me share my story with you. Let me tell you how thousands of my patients, as well as myself, have realized permanent weight loss reduction. Remember, we cannot change our genetic code. However, we can learn to modify and adjust our genetic foundations and live a healthy, happy, and well life!

I look forward to meeting you!

Michelle Haendiges, MD

↑ LAST NAME ↑	↑ FIRST NAME ↑	↑ M.I. ↑

STREET ADDRESS	CITY	STATE	ZIP CODE

DATE OF BIRTH	HOME PHONE	CELL PHONE

SOCIAL SECURITY #	MARITAL STATUS	SPOUSE'S NAME

EMPLOYER	EMPLOYER PHONE #

EMERGENCY CONTACT	EMERGENCY PHONE #	PRIMARY CARE PHYSICIAN
WHO REFERRED YOU?		

<input type="checkbox"/>	PLEASE CHECK IF YOU AUTHORIZE AND CONSENT THE VERBAL DISCLOSURE OF HEALTH INFORMATION TO THE FOLLOWING RECIPIENTS. PLEASE UNDERSTAND THAT THIS AUTHORIZES HAENDIGES & ASSOCIATES TO RELEASE APPOINTMENT INFORMATION AND GENERAL HEALTH INFORMATION TO THE LISTED NAMES. THIS CONSENT WILL BE IN EFFECT UNTIL WRITTEN NOTICE IS RECEIVED BY OUR OFFICE.
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↑ NAME OF RECIPIENT ↑	↑ RELATIONSHIP TO PATIENT ↑

DR. HAENDIGES IS DISTRIBUTING INFORMATIVE MATERIALS & RESOURCES FOR NUTRITION. PLEASE INCLUDE YOUR NAME AND EMAIL ADDRESS IF YOU WOULD LIKE TO RECEIVE THIS INFORMATION. YOUR EMAIL ADDRESS IS CONFIDENTIAL AND WILL NOT BE SHARED OR PUBLISHED.

YES! I WANT TO RECEIVE ALL INFORMATION PERTAINING TO NUTRITION.

NO, I DO NOT WISH TO PROVIDE MY EMAIL ADDRESS.

EMAIL ADDRESS:

I VERIFY THAT THE INFORMATION LISTED ABOVE IS TRUE AND ACCURATE AS OF TODAY'S DATE.

PATIENT SIGNATURE (GUARANTOR IF PATIENT IS A MINOR)	DATE



WEIGHT CONTROL EXPECTATIONS QUESTIONNAIRE

The accompanying explanatory sheet discusses the importance of clearly delineating your expectations when participating in any kind of weight control program. This form has been designated to assist you in organizing your thoughts regarding exactly what it is you want for yourself. By first filling out this questionnaire as completely as possible, and then reviewing it with your physician, you will learn what can reasonably be expected to occur.

How did you hear about us? _____

On a scale of 1-10, with 10 being the highest, how motivated are you to lose weight?

1 2 3 4 5 6 7 8 9 10

How much weight do you expect to lose? _____

Each week? _____ Each month? _____

What will happen if you don't lose that much or that fast? How will you react? _____

What size clothes do you expect to be able to wear when you reach your goal weight? _____

What do you expect from us (your medical counselors)? Be specific: _____

Will it change your life in any way (for better or worse) when you reach your goal weight?

Do you expect to be doing anything you are not doing now? Explain: _____

Do you expect to stop doing something you are doing now? Explain: _____

Will your "new, normal weight self" pose a threat to your relationship with significant others?

How will family and friends respond to the new you? _____

Do you expect to get a better job? _____

Will you get more respect from other people? _____

Will you be more sociable than you are now? _____

What will happen if some of your expectations don't come true? _____

What do you expect to have to do to maintain your weight? _____

Will you continue to watch your food intake? _____ Exercise? _____

Continue with professional medical monitoring? _____ For about how long? _____

Do you have any other expectations than those listed above? _____ Explain:

Patient Name: _____ Date: _____

Email Address: _____



Health History Summary

Patient Name _____ DOB _____

Please list your diet history:			
Diet Description	Success yes/no	Weight loss (lbs)	Maintain yes/no

Please List any Current Medications:		
Drug Name	Dosage	Who Prescribed

Please List your Social History:			
	Yes	No	
Do you smoke?			If yes, how many packs? Number of Years?
Alcohol			If yes, how many drinks per week?
Recreational Drug Use			If yes, what kind?
Regular Exercise			If yes, how often?

Please list any Operations or Hospitalizations:		
Reason	Date	Hospital

Allergies:					
None	Medication	Latex	Other		
If yes, please list:					

Please list your preferred Pharmacy & Location:

Please specify your personal / family history of illness:			
Illness	Personal	Family	Please indicate dates of illness. If illness occurred in family member, please list how related.
Alcohol or Drug problems			
Alzheimer's disease			
Anemia			
Arthritis/Back problems			
Asthma			
Birth defects			
Blood clots			
Bowel problems			
Breast cancer			
Broken bones			
Cancer			
Cataracts			
Chickenpox			
Colon cancer			
Depression / Anxiety			
Diabetes			
Eating disorders			
Fibroids			
Glaucoma			
Heart attack/disease			
Hepatitis/liver damage			
High blood pressure			
High cholesterol			
HIV/AIDS			
Infertility			
Kidney infections/stones			
Lupus			
Osteoporosis			
Ovarian cancer			
Reflux/ulcers			
Rheumatic fever			
Seizures			
STD			
Stroke			
Thyroid disease			
Tuberculosis			
Uterine cancer			
Other			

Patient Signature		Date	
If form was completed by someone other than the patient, please list name and relationship:			

Sleep Screening

Please check the following as they apply to you:

	Question	Yes	No
2	Do you snore?		
2	If you snore, do others say your snoring is interrupted by choking/snoring?		
2	Do others say you stop breathing while you sleep?		
2	Do you have trouble staying awake when you want to be awake?		
2	Do you fall asleep during any of the following? Watching TV: _____ Never _____ Rarely _____ Some _____ Frequent While at Work: _____ Never _____ Rarely _____ Some _____ Frequent Movie, Church: _____ Never _____ Rarely _____ Some _____ Frequent		
1	Do you fall asleep frequently while reading books or newspaper?		
2	Have you ever fallen asleep while driving?		
1	Do you have trouble getting to sleep or staying asleep when you want to sleep?		
1	Do you feel tired after 8 hrs of sleep?		
1	Do you frequently get less than 7 hours of sleep in 24 hours?		
1	Do you have restless legs or crawling feelings in your legs when you sit or lie down?		
1	Do others say you have jerking movements of your legs during sleep?		

5 or less=LOW

5-8=Moderate

Above 8=High Risk

Total: _____

Dr. Haendiges' Medical Weight Loss Patient Questionnaire

Name		Date	
Mailing Address			
E-mail address	Home Phone	Work Phone	

Please complete the following (strictly confidential):

1. When did you begin to gain weight?
 - After childbirth After marriage
 - After an employment change
 - During a stressful period
 - Other

2. How long have you been overweight?
 - 1 year or less 2-5 years
 - 6-10 years 10 years

3. What do you feel is the reason for your weight problem?
 - Frequently overeat
 - Enjoy fattening foods
 - Lack of activity
 - Heredity
 - Other _____

4. How many meals do you eat daily? _____

5. How many serious attempts have you made at dieting? _____

6. How long have you been able to stick to a diet?
 - 0-1 month 2-6 months
 - 7-12 months Over 12 months

7. What other weight reduction methods have you tried?
 - Weight Watchers Other diet centers
 - Diet books Physicians
 - Do it yourself

8. Why have you dropped out of diets before?
 - Boredom Hunger
 - Stress Need assistance
 - Other _____

9. What is the nature of your difficulties while dieting?

10. Are you under a physicians care?
 - Yes No

11. Have you been advised by your physician to lose weight?
 - Yes No

12. Do you have any physical problems that you know are associated with your weight?
 - Yes No

13. Why do you want to lose weight?
 - Promotes social activity
 - Appearance
 - Special Occasion _____
 - Health reasons
 - To please family/friends
 - Other _____

14. Has your husband or wife encouraged you to lose weight? Yes No

15. How important is it to you to lose weight?
 - Extremely Important
 - Very important
 - Important
 - Not very important

16. Do you work outside the home?
 - Yes No
 - Full-time Part-time
 - Occupation _____

17. Sex
 - Male Female

18. Age
 - Under 18 18-24 25-34
 - 35-49 50-64 Over 64

19. Marital Status
 - Married Divorced Single
 - Widowed Living with partner

20. Number of Children _____ Ages: _____

21. Are any of your children overweight?
 - Yes No

22. What is your current weight? _____ lbs.

23. What was your highest weight in the last 5 years? _____ lbs.

24. What was your lowest weight in the last 5 years? _____ lbs.

25. What is your goal weight? _____ lbs.

Driving Directions



Haendiges & Associates, PC
2030 W Boulevard
Kokomo, IN 46902

1. Head South on US 31
2. Take Downtown Exit for Kokomo
3. Continue on Washington St
4. Turn right at IN-22 (W Sycamore St)
5. Turn left at S Dixon Rd
6. Turn left at W Boulevard

1. Head East on IN St Rd 26
2. Turn left at 200 W
3. Turn right at W Boulevard

1. Head West on IN St Rd 22/US 35
2. Turn left at Park Rd
3. Turn right at W Defenbaugh St
4. Turn left at S Berkley Rd
5. Turn right at W Boulevard

1. Head North on US 31
2. Turn left at IN St Rd 26
3. Turn right at Park Rd
4. Turn left at W Boulevard

