Medical Weight Loss

Medical History Form

Patient Name: _____ DOB: _____/_____/_____

I first became concerned about my weight at age: _____

I started gaining weight because: _____

My weight at age 20 was _____ lbs. What is your weight TODAY? _____ lbs.

My weight one year ago was _____ lbs. What is your current height? _____ ft. _____ in.

The most I ever weighed (non-pregnant) was _____ lbs.

My MOST IMPORTANT reasons for wanting to get my weight under control are:

_____

_____

Weight Loss Programs or Diets I have tried before include:

_____

I have used weight loss medications before (Circle one): YES NO

If you answered "YES" to the previous question, please indicate which medications you have used below:

_____

_____

I am currently using weight loss products. (Circle one): YES NO

If you answered "YES" to the previous question and are using weight loss products, please indicate which products you are currently using below:

_____

_____

The person(s) closest to me support my intentions to do this program (Circle one):

YES NO UNSURE

Long-term, I would like to maintain my weight at _____ lbs.

I would like to be at my "New Climate" weight in _____ months/years.

FEMALES ONLY: Is there any chance you are currently pregnant? YES NO

FEMALES ONLY: Are you planning to become pregnant in the next year? YES NO

My regular Doctor/Care Provider is _____ in which location/town?:
_____

Would you like us to communicate with your regular doctor about your care here at ReforMedicine? *Communication in healthcare is important for you to receive the most comprehensive care possible.*

YES NO

Previous or current health conditions I have had include: *Check all that apply to you.*

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Chronic Leg Swelling
- ☐ Bipolar
- ☐ Night Eating Syndrome
- ☐ Sleep Apnea
- ☐ COPD
- ☐ Irritable Bowel Syndrome
- ☐ Fatty Liver Disease
- ☐ Ulcerative Colitis
- ☐ Stomach Ulcers
- ☐ Thyroid Problems
- ☐ Urinary Incontinence
- ☐ Other: _____
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Bleeding Disorder
- ☐ Eczema
- ☐ Cancer
- ☐ Depression
- ☐ PTSD
- ☐ Anorexia Nervosa
- ☐ ADD/ADHD
- ☐ Crohn's Disease
- ☐ Menopause
- ☐ Colitis
- ☐ Liver/Gallbladder Disease
- ☐ Fibromyalgia
- ☐ Blood Clot
- ☐ Anemia
- ☐ Headache/Migraine
- ☐ Anxiety
- ☐ Binge Eating Disorder
- ☐ Bulemia
- ☐ Alcohol/Drug Abuse
- ☐ Restless Leg Syndrome
- ☐ Asthma
- ☐ Acid Reflux
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Polycystic Ovaries
- ☐ Gout

Prescription Medications I CURRENTLY take are:

Please indicate the medication names, doses, and frequency of each below.

_____

_____

Over the Counter (OTC) and Supplements/Vitamins I CURRENTLY take are:

Please indicate the medication names, doses, and frequency of each below.

_____

_____

I am allergic to, or do NOT tolerate, the following medications:

If not applicable, you may skip this and move on to the next question.

_____

Surgeries I have EVER had previously include:

Please indicate the type of procedure and date for each below. If none, you may skip and continue on to the next question.:

_____

_____

Hospitalizations and/or Serious Injuries I have EVER had previously include:

Please include the reason for hospitalization, the hospital name, and date for each.

_____

_____

Have you ever experienced significant TRAUMA in your life?: YES NO

Near death, witnessing or victim of abuse, terrible accident, etc.

If you answered "YES" to the previous question, have you ever sought counseling for the effects of trauma?

YES NO

Family Health History: FATHER - Living? YES NO

Family Health History: FATHER - Age? _____ years

Family Health History: FATHER

Select all conditions, current or previous, that apply.

☐ Heart Attack/Stroke ☐ Psychiatric ☐ Cancer

☐ Diabetes ☐ Obesity ☐ Other: _____

Family Health History: MOTHER - Living? YES NO

Family Health History: MOTHER - Age? _____ years

Family Health History: MOTHER

Select all conditions, current or previous, that apply.

☐ Heart Attack/Stroke ☐ Psychiatric ☐ Cancer

☐ Diabetes ☐ Obesity ☐ Other: _____

Family Health History: Sibling #1

If no siblings, you may skip the "Family History - Sibling" questions. BROTHER SISTER

Family Health History: Sibling #1

Sibling 1 - Living? YES NO

Family Health History: Sibling #1

Sibling 1 - Age? _____ years

Family Health History: SIBLING #1

Select all conditions, current or previous, that apply.

☐ Heart Attack/Stroke ☐ Psychiatric ☐ Cancer

☐ Diabetes ☐ Obesity ☐ Other: _____

Family Health History: Sibling #2 BROTHER SISTER

Family Health History: Sibling #2

Sibling 2 - Living? YES NO

Family Health History: Sibling #2

Sibling 2- Age? _____ years

Family Health History: SIBLING #2

Select all conditions, current or previous, that apply.

☐ Heart Attack/Stroke ☐ Psychiatric ☐ Cancer

☐ Diabetes ☐ Obesity ☐ Other: _____

Family Health History: Sibling #3 BROTHER SISTER

Family Health History: Sibling #3

Sibling 3 - Living? YES NO

Family Health History: Sibling #3

Sibling 3 - Age? _____ years

Family Health History: SIBLING #3

Select all conditions, current or previous, that apply.

☐ Heart Attack/Stroke ☐ Psychiatric ☐ Cancer

☐ Diabetes ☐ Obesity ☐ Other: _____

My current situation...

I am:

☐ Married ☐ Widow/Widower ☐ Other: _____

☐ Never Married ☐ Divorced

I have _____ number of children.

☐ 0 ☐ 3 ☐ 2

☐ 1 ☐ 4 ☐ Other: _____

I live at home with:

Please include the names and ages of everyone you live with.

_____

_____

The city/town I currently live in is:

_____

For a living I... (occupation):

_____

At this time, my exercise routine includes...:

Please include activity type, how many minutes, and how many times/week.

_____

My current stress level is:

☐ None ☐ Medium

☐ Low ☐ High

My biggest stressor is:

☐ Job ☐ Relationship

☐ Health ☐ Other: _____

My tobacco use is:

☐ Current ☐ Never

☐ Former ☐ Quitting

My current alcohol use is...

☐ None ☐ Daily ☐ Weekly

☐ Occasional ☐ A problem

My current recreational substance use is...:

Please include type and frequency of use, if none, write "none."

_____

My TV/computer time per week is...

☐ Less than 7 hours ☐ More than 15 hours ☐ 7-15 hours

Symptoms I am currently experiencing: *Check all that apply to you.*

- [ ] Unexpected Weight Loss/Gain
- [ ] Swollen glands
- [ ] Fevers/chills/sweats
- [ ] Eye pain
- [ ] Voice change
- [ ] Rapid/pounding heart
- [ ] Chest pain
- [ ] Blood in sputum
- [ ] Loud snoring
- [ ] Not well rested after a full night's sleep
- [ ] Ulcers/Wounds on feet
- [ ] Change in bowel habits
- [ ] Abdominal pain
- [ ] Nausea or vomiting
- [ ] Black tar/blood in stools
- [ ] Diarrhea
- [ ] Blood in urine
- [ ] New/unusual headaches
- [ ] Skin rashes
- [ ] Changing moles
- [ ] Low sex drive
- [ ] Feeling sick
- [ ] Longstanding pain
- [ ] Disturbance in vision
- [ ] Hearing loss
- [ ] Faints
- [ ] Shortness of breath
- [ ] Cough
- [ ] Wheezing
- [ ] Stop breathing during sleep
- [ ] Swelling in legs/ankles
- [ ] Calf or leg pain while walking
- [ ] Heartburn
- [ ] Painful or difficult swallowing
- [ ] Yellow skin/eyes
- [ ] Constipation
- [ ] Trouble emptying bladder
- [ ] Painful urination
- [ ] Urinating too frequency
- [ ] Abnormal urge to urinate
- [ ] Abnormal bleeding/bruising
- [ ] WOMEN ONLY: Nipple discharge
- [ ] Urinary incontinence
- [ ] Joint swelling
- [ ] Unexplained lumps or masses
- [ ] Anxiety/Nervousness
- [ ] Falling down
- [ ] Unexplained hair loss
- [ ] Drinking too much
- [ ] MEN ONLY: Erectile Dysfunction
- [ ] WOMEN ONLY: Pelvic pain

At this time, my overall health is:

☐ Excellent ☐ Fair

☐ Good ☐ Poor

Have you ever had a sleep study or been told that you need one?

YES NO

I've decided to come to ReforMedicine Medical Weight Loss to help me lose weight because...

_____

_____

ReforMedicine SC

Updated: 12/23

POLICIES:

Communication is key in providing superior care and achieving optimal results. We will do our utmost to communicate clearly and meet your expectations. In turn, you will also be expected to communicate clearly with our team. Please inform us if you must miss an appointment or change your care plan in some way. In order for us to provide optimal access to care and achieve the best outcomes for you, the following policies apply to the ReforMedicine Medical Weight Loss Program.

_____
(Initial Here)

1. Your initial medical weight loss enrollment includes 5 appointments to get started. In order to set aside this amount of time for a single patient, it **MUST BE PRE-PAID.**

   a. Failure to Show Up for an Appointment as scheduled, or cancelling with notice of **less than one business day** will result in forfeiture of Initial Medical Weight Loss Fees.
   b. To reschedule, another complete Initial Medical Weight Loss program fee must be pre-paid.

_____
(Initial Here)

2. Patients should call the clinic if an appointment must be cancelled or rescheduled **at least one business day** prior to scheduled appointment.

_____
(Initial Here)

3. Failure to show up for a pre-appointed Follow Up visit, or **failure to cancel at least one business day** prior to the scheduled visit will result in the need to **pay for the missed visit**, **AND pre-pay the next Medical Weight Loss Visit.**

_____
(Initial Here)

4. Consistent, regular provider follow-up is essential to the success of my Medical Weight Loss program. If a situation arises that requires me to be absent for up to 6 months from my routine follow-ups it is my responsibility to notify my provider, in advance, that I will not be able to come to clinic for some period of time. If I do not make this prior arrangement with my provider and more than 90 days have passed since my last appointment, I will be required to pay a Re-Engagement Fee (see 5.b. below) in order to resume my program.

_____
(Initial Here)

5. Prolonged absence from routine provider visits, (without prior arrangement) between patient and her/his provider, is considered a situation of very high risk for poor weight-loss outcomes.

   a. **Grace Period:** If a patient has not been seen in a month or two, but has not "no-showed" **AND** less than 90 days have passed between patient's last provider appointment and a subsequent provider appointment, the patient may resume progress appointments **without** a Re-Engagement Fee.

   b. **Re-Engagement:** If more than 90 days but less than 180 days have passed between provider appointment, it is assumed the patient has been off the ReforMedicine Eating Plan. A **pre-paid Re-Engagement Fee of $270** will apply in order to schedule a visit to resume the weight loss program. This fee includes the SINGLE provider visit and new health coaching visit.

_____
(Initial Here)

6. If **more than 180 days have passed** since the last weight loss provider visit, a patient who wishes to resume the program will need to request our and view our virtual MWL Information Session video to **RE-START** the program. Re-starting **requires pre-payment of full Initial Medical Weight Loss Fees.**

_____
(Initial Here)

7. No weight loss medications will be prescribed for any patient outside the context of the ReforMedicine Medical Weight Loss program, nor outside the setting of the usual office visit. Weight loss medications are prescribed in a manner similar to any other medications that medical providers prescribe. If it is determined to not be helpful in achieving results, or is detrimental to the patient, the provider has the sole discretion regarding its continued use.

_____
(Initial Here)

8. From time to time, patients will request assistance with issues NOT directly related to Medical Weight Loss. If the patient has no primary care provider, or if seeing that provider is not possible and **the patient requests** that the Medical Weight Loss provider evaluate and treat a non-weight related issue, AND **time allows** for evaluation during the current scheduled Medical Weight Loss appointment, the ReforMedicine provider may agree at his/her sole discretion to evaluate and recommend treatment options for such an issue.

***NOTE: This additional service will require a completely separate office visit and office visit charge at the appropriate current FFS fee level (Level 1 or Level 2) depending on the issue addressed. **The patient will be responsible for paying this addional fee AT THE TIME OF SERVICE.**

I have read the above policies and agree to be held accountable to these terms.

_____ _____

Signature Date

ReforMedicine SC

Medical Weight Loss Program

Anxiety Screening Tool (GAD-7)

Choose the ONE description for each item that best describes **how many days** you have been bothered by each of the following over the past **two weeks:**

	None	Several	7 +	Nearly every day
Feeling nervous, anxious, or on edge	☐	☐	☐	☐
Unable to stop worrying	☐	☐	☐	☐
Worrying too much about different things	☐	☐	☐	☐
Problems relaxing	☐	☐	☐	☐
Feeling restless or unable to sit still	☐	☐	☐	☐
Feeling irritable or easily annoyed	☐	☐	☐	☐
Being afraid that something awful will happen	☐	☐	☐	☐

Scoring:

Sum scores from each question:

None = 0
Several = 1
7 or more = 2
Nearly every day = 3

Total Score: _____

A total score of 5 - 9 suggests mild anxiety.
A total score of 10 or higher suggests moderate - severe anxiety

Scanned: _____

With permission from: Marcus DA. Chronic Pain. A Primary Care Guide to Practical Management, 2nd edition, HumanaPress, Totowa, NJ, 2008. An adaptation of the General Anxiety Disorder-7 (GAD-7). The GAD-7 is a 7-item, self-report, anxiety screening tool, which was developed and validated by Spitzer and colleagues for use in primary care. [Spitzer RL, et al. A Brief Measure for Assessing Generalized Anxiety Disorder: The GAD-7. Arch Intern Med. 2006;166:1092-1097.]

Medical Weight Loss Program

Patient Health Questionnaire - 2 (PHQ - 2)

Over the last **two weeks**, how often have you been bothered by any of the following problems? (Please circle a number.)

	Not at all	Several Days	Over half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

For Office Use: _____ + _____ + _____ + _____

= Total Score: _____

STOP - Bang Questionnaire

NO	YES	
☐	☐	**Snoring?** Do you Snore loudly? (Loud enough to be heard through the closed doors or. your bed-partner elbows you for snoring at night?)
☐	☐	**Tired?** Do you often feel Tired, Fatigued, or Sleeping during the daytime (such as falling asleep during driving or talking to someone?)
☐	☐	**Observed?** Has anyone Observed you Stop Breathing or Choking/Gasping in your sleep?
☐	☐	**Pressure?** Do you have, or are you being treated for High Blood Pressure?
☐	☐	**BMI** Body Mass Index more than 35 kg/m2?
☐	☐	**Age older than 50?**
☐	☐	**Neck size Large?** *Measured around the Adam's apple. For males, is your shirt collar 17 inches/43 cm or larger? For females, is your shirt collar 16 inches/41 cm or larger?
☐	☐	**Gender = Male?**

Score Criteria:

For general population:
Low Risk of OSA: Yes to 0-2 questions
Intermediate Risk of OSA: Yes to 3-4 questions
High Risk of OSA: Yes to 5-8 questions

or Yes to 2 or more of 4 STOP questions + Male gender
or Yes to 2 or more of 4 STOP questions + BMI > 35 kg/m2
or Yes to 2 or more of 4 STOP questions + neck circumference (17"/43cm in Male, 16"/41cm in female)

Medical Weight Loss Program

Adult ADHD Self-Report Scale Symptom Checklist

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt & conducted yourself over the past 6 months. Please give this completed checklist to your healthcare provider to discuss during today's appointment.

	Never	Rarely	Some-times	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	☐	☐	☐	☐	☐
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?	☐	☐	☐	☐	☐
3. How often do you have problems remembering appointments or obligations?	☐	☐	☐	☐	☐
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	☐	☐	☐	☐	☐
5. How often do you fidget or squirm with your hands or feet when you sit down for a long time?	☐	☐	☐	☐	☐
6. How often do you feel overly active & compelled to do things, like you were driven by a motor?	☐	☐	☐	☐	☐

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?	☐	☐	☐	☐	☐
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?	☐	☐	☐	☐	☐
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?	☐	☐	☐	☐	☐
10. How often do you misplace or have difficulty finding things at home or at work?	☐	☐	☐	☐	☐
11. How often are you distracted by activity or noise around you?	☐	☐	☐	☐	☐
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?	☐	☐	☐	☐	☐
13. How often do you feel restless or fidgety?	☐	☐	☐	☐	☐
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?	☐	☐	☐	☐	☐
15. How often do you find yourself talking too much when you are in social situations?	☐	☐	☐	☐	☐
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you're talking to, before they can finish themselves?	☐	☐	☐	☐	☐
17. How often do you have difficulty waiting your turn in situations when turn taking is required?	☐	☐	☐	☐	☐
18. How often do you interrupt others when they are busy?	☐	☐	☐	☐	☐

Part B

Scanned: _____

ReforMedicine SC

Updated: 12/23

Medical Weight Loss Program

Binge Eating Disorder Screener (BEDS-7)

The following questions ask about your eating patterns and behaviors within the last 3 months. For each question, choose the answer that best applies to you.

1. **During the last 3 months**, did you have any episodes of excessive overeating (i.e., eating significantly more than what most people would eat in a similar period of time?) Yes No

*****NOTE: IF YOU ANSWERED "NO" TO QUESTION 1, YOU MAY STOP. THE REMAINING QUESTIONS DO NOT APPLY TO YOU.*****

2. Do you feel distressed about your episodes of excessive overeating? Yes No

Within the past 3 months...

	Never or Rarely	Sometimes	Often	Always
3. **During your episodes of excessive overeating**, how often did you feel like you had no control over your eating? (e.g., not being able to stop eating, feel compelled to eat, or going back and forth for more food?)				
4. **During your episodes of excessive overeating**, how often did you continue eating even though you were not hungry?				
5. **During your episodes of excessive overeating**, how often were you embarrassed by how much you ate?				
6. **During your episodes of excessive overeating**, how often did you feel disgusted with yourself or guilty afterward?				
7. **During the last three months**, how often did you make yourself vomit as a means to control your weight or shape?				

ReforMedicine SC

Medical Weight Loss Program Consent Form

I, _____, authorize my ReforMedicine, SC physician(s), or advanced practice clinician(s) and/or whomever may be designated as the medical assistant(s), to help me in my weight reduction efforts. I understand that my program will consist of a prescribed diet, a regular exercise program, instruction in behavioral modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low caloric diet, some form of fasting, or a protein supplemented diet. I further understand that if appetite suppressants are prescribed, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me to my complete satisfaction that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the medication product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks associated with remaining overweight are tendencies to have high and increasing higher blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances made to me that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require drastic changes in eating habits and permanent changes in behavior to be treated successfully.

NO SHOW POLICY:

I understand that failing to show up for an appointment I have scheduled, without calling or contacting ReforMedicine ahead of time, represents a disruption to operation of the clinic. Failure to show up ("No Show") for a pre-appointed Follow-Up Visit, or failure to cancel ***at least one full business day*** prior to a scheduled visit will result in the need to **pay for the missed visit, and pre-pay the next Medical Weight Loss visit.**

I have read and fully understand this consent form and "No Show" policy. I have had all of my questions answered to my complete satisfaction. I have been given all the time that I need to carefully read and understand this form.

_____ **(Initials) I acknowledge that I have had an opportunity to review ReforMedicine S.C.'s HIPAA Policy and also acknowledge that if I should request a copy, a copy will be provided to me.**

Patient Full Name (signed): _____

*Or other person(s) with authority to consent for this patient

ReforMedicine SC

Medical Weight Loss: Health Coaching Policy & Agreement

*24 HOUR NOTICE IS REQUIRED IF A NEED ARISES TO CANCEL OR RE-SCHEDULE APPOINTMENT

1. I understand that the first 3 health coaching visits within the first 3 months of my participation in the MWL program are included in my Initial Enrollment Bundle and are exempt from the No-Show fee policy (#2 below). If I "No-Show" any of these 3 visits it is considered forfeit and cannot be re-scheduled. I understand every health coaching visit beyond the first 3 visits or outside of the first three months (whichever comes first) will cost $50/visit (**contracted Near Site & On-Site Clinic Employer Group fees may vary, please ask to confirm your cost**) that must be pre-paid at the time of scheduling and are subject to the No-Show fee policy as outlined below (2.)

2. I understand that all health coaching sessions (in-person or phone/e-visit) are considered a scheduled appointment time. I am aware that if I cannot make my scheduled appointment, it is my responsibility to call and cancel or reschedule at least 1 full business day prior to scheduled appointment. Failure to show up for a pre-appointed Health Coach Visit, or failure to cancel at least one full business day prior to a scheduled visit will result in a No-Show fee charge of $50 (variable per SC) AND I may not be scheduled for future visits until fee is paid.

3. As a client, I understand and agree that I am fully responsible for my physical, mental and emotional well-being during my coaching calls, including my choices and decisions. I am aware that I can choose to discontinue coaching at any time. I am also aware that the health coach may discontinue health coaching if multiple No-Shows occur.

4. I understand that “coaching” is a Professional-Client relationship I have with my coach that is designed to facilitate the creation and development of wellness goals to develop and carry out a plan for achieving those goals.

5. I understand that coaching is a comprehensive process that may involve all areas of my life. Utilizing a whole person approach may include discussing subjects such as work, finances, health, relationships, education, spiritual and recreation. I acknowledge that deciding how to discuss these issues, incorporate coaching into those areas if needed, and implement my choices is exclusively my choice and personal responsibility.

6. I understand that coaching does not involve the diagnosis or treatment of mental disorders as defined by the American Psychiatric Association. I understand that coaching is NOT a substitute for counseling, psychotherapy, psychoanalysis, mental health care or substance abuse treatment. I also agree that I will not use it in place of any form of diagnosis, treatment or therapy.

7. I promise that if I am currently in therapy or otherwise under the care of a mental health professional, that I have consulted with the mental health care provider regarding the advisability of working with a health coach.

8. I understand that my information will be held as confidential and only shared as needed between the health coach and provider for best health outcomes, unless I state otherwise, in writing, except as required by law.

9. I understand that coaching is not to be used as a substitute for professional advice by legal, medical, financial, business, spiritual or other qualified professionals. I will seek independent professional guidance for legal, medical, financial, business, spiritual or other matters. I understand that all decisions in these areas are exclusively mine and I acknowledge that my decisions and my actions regarding them are my sole responsibility.

What is your preferred method of contact? *Circle one*.

IN-PERSON E-VISIT PHONE

I have read and agreed to the above. All of my questions about the role of the Health Coach have been answered to my satisfaction.

_____

Patient Signature:

DOB: _____ / _____ / _____

ReforMedicine SC

Health Coaching Information:

Preferred Patient Contact Information:

_____

Barriers to Care:

Please indicate any barriers you may be facing.

☐ Family ☐ Financial

☐ Work ☐ Other: _____

Support System:

Please select all that apply for your personal support system.

☐ Family ☐ People at work

☐ Friends ☐ Other: _____

☐ Community Program

On a scale of 1-10, how ready are you to make lifestyle changes?:

☐ 0 = Not really ready.

☐ 5 = Might be ready for change...

☐ 10 = Really ready to make some changes!

On a scale of 1-10, how confident are you that you can make lifestyle changes?:

☐ 0 = Not confident at all.

☐ 5 = Somewhat confident

☐ 10 = Really confident!

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