Welcome to Vivify Wellness Center!!

Our mission at Vivify Wellness Center is to empower patients to change their lives by providing education and individualized plans. We believe that a weight loss plan should be customized to each patient. We offer an array of tools to assist you achieve a healthier you, from the inside out. It is our goal to provide these tools in a compassionate, safe environment in a physician's office that specializes in medical weight management.

It is not necessary to purchase our nutritional supplements, exercise programs, meal replacements or to take appetite suppressants to lose weight in our program. Our philosophy is to provide education to change your life through proper nutrition, behavior changes and increased activity. We want to promote a lifestyle change, not a diet.

Each visit to our center is about education. Follow-up visits are scheduled based on your individualized program. Most follow-up visits are monthly, but follow up visits in our rapid weight loss programs are weekly.

As a patient of Vivify Wellness Center, you will have access to the most up to date nutrition information, customized meal plans and tools for logging your diet and exercise that will be monitored by your physician.

Attached, you will find our new patient paperwork. Please complete the forms prior to your first appointment, as this is one of the first things we review at your appointment.

***If the paperwork is not completed prior to the appointment, we may need to reschedule your appointment.**

If you are unable to print these forms, please arrive 30 minutes early to your appointment to complete your paperwork. Please allow adequate time, for the paperwork is extensive, to provide the information needed to customize your plan. We also ask that you be on time for any appointments scheduled. Even being just a few minutes behind could possibly result in having to reschedule your appointment. Please plan to be with us for up to 2 hours on your first visit as you will have lab work, and EKG and an extensive visit with Dr. Anamekwe that includes a physical.

Please contact us by phone at (972) 941-8484 if you have any questions about your first appointment.

We are located at 500 S. Westgate Way Suite 300 Wylie, Texas 75098. We are located behind the Arby's on the corner of Westgate Way and FM 544.

We look forward to guiding you towards a healthier lifestyle and a healthier you!!

Sincerely,
Dr. Kene Anamekwe and Staff

Patient Rights and Responsibilities

This document is meant to inform our patients of their rights and responsibilities while undergoing medical care. To the extent permitted by law, patient rights may be exercised on behalf of the patient by his or her guardian, next of kin, or legally authorized responsible person if the patient: A) has been adjudicated incompetent in accordance with the law, B) is found to be medically incapable of understanding the proposed treatment or procedure, C) is unable to communicate his or her wishes regarding treatment, or D) is a minor. If there are any questions regarding the contents of this notice, please notify any staff member.

Patient Rights

1. Access to care. You will be provided with impartial access to treatment and services within Vivify Wellness Center's capacity, availability and applicable law and regulation. This is regardless of race, creed, sex, national origin, disability/handicap or source of payment for care/service.
2. Respect and Dignity. You have the right to considerate, respectful care/services at all times and under all circumstances. This includes recognition of psychosocial, spiritual and cultural variables that may influence the perception of your illness.
3. Personal Safety. You have the right to expect reasonable safety insofar as the office practices and environment are concerned.
4. Identity. You have the right to know the identity and professional status of any person providing services and which provider or other practitioner is primarily responsible for care.
5. Information. You have the right to obtain complete and current information concerning diagnosis, treatment and any known prognosis. This information should be communicated in terms that you understand.
6. Communication. If you do not speak or understand the predominant language of the community, you should have access to an interpreter. This is particularly true when language barriers are a continuing problem.
7. Consent. You have the right to information that enables you, in collaboration with the provider, to make treatment decisions.
   a. Consent discussions will include explanation of the condition, likely risks and benefits of treatment, as well as likely consequences of no treatment.
   b. You will not be subjected to any procedure without providing voluntary, written consent.
   c. You will be informed if Vivify Wellness Center proposes to engage in research or experimental projects affecting its care or services. If it is your decision not to take part, you will continue to receive the most affective care Vivify Wellness Center otherwise provides.
8. Consultation. You have the right to accept or refuse medical care to the extent permitted by law. However, if refusing treatment prevents Vivify Wellness Center from providing appropriate care in accordance with ethical and professional standards, your relationship with Vivify Wellness Center may be terminated upon reasonable notice.
9. Charges. Regardless of the source of payment for care provided, you have the right to request and receive itemized and detailed explanations of any services.

Patient Responsibilities

1. Keep us accurately informed. You have the responsibility to provide, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to your health, including unexpected changes in your condition.
2. Follow your treatment plan. You are responsible for following the treatment plan recommended by the provider. This may include following the instructions of health care personnel as they carry out the coordinated plan of care and implement the provider's orders and as they enforce the applicable Vivify Wellness Center rules and regulations.
3. Keep your appointment. You are responsible for keeping and, when unable to do so for any reason, for notifying Vivify Wellness Center.
4. Take Responsibility for noncompliance. You are responsible for your actions if you do not follow the provider's instructions. If you cannot follow through with the prescribed treatment plan, you are responsible for informing the provider.
5. Be responsible for your financial obligations. You are responsible for assuring that the financial obligations of health care services are fulfilled as promptly as possible, and for providing up-to-date information.
6. Be considerate of others. You are responsible for being considerate of the rights of other patients and personnel, and for assisting in the control of noise, smoking, and the number of visitors. You are also responsible for being respectful of Vivify Wellness Center property and property of other persons visiting Vivify Wellness Center.
7. Be responsible for lifestyle choices. Your health depends not just on the care provided at this facility but on the long-term decisions you make in daily life. You are responsible for recognizing the effects of these decisions on your health.

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **Vivify Wellness Center** to use and/or disclose certain protected health information (PHI) about me to (person/company authorized to receive information) _____
_____.

This authorization permits **Vivify Wellness Center** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service, types of services, level of detail to be released, origin of information, etc.): _____
_____
_____

The information will be used or disclosed for the following purpose: _____
_____

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual.")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____.

I do not have to sign this authorization in order to receive treatment from **Vivify Wellness Center**. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

Vivify Wellness Center
500 S. Westgate Way
Suite 300
Wylie, Texas 75098

Signature of Patient or Legal Guardian: _____ Date: _____

Print Patient's Name: _____ Relationship to Patient: _____

Print Name of Legal Guardian, if applicable: _____

FIRST NAME: _____ **MI:** _____ **LAST NAME:** _____

NICKNAME: _____ **EMPLOYER:** _____ **DOB:** _____ **GENDER: M F**

MAILING ADDRESS: _____ **APT:** _____

CITY: _____ **STATE:** _____ **POSTAL CODE:** _____

CELL: _____ **HOME:** _____ **WORK:** _____**EXT:** _____

EMAIL ADDRESS: _____

REFERRED BY: _____**PATIENT NAME:** _____ _____**MAGAZINE NAME:** _____
_____**INTERNET SEARCH** _____**ONLINE COUPONS** _____**OTHER:** _____

SOCIAL SECURITY # AND/OR DRIVER'S LICENSE # WITH STATE (For Weight Loss and Family Medicine Patients ONLY):
_____

PRIMARY CARE PHYSICIAN (For Weight Loss and Family Medicine Patients ONLY): _____

MAY DR. KENE ANAMEKWE CONTACT THIS PHYSICIAN IN REFERENCE TO YOUR CARE: N Y

IF YES, PLEASE PROVIDE A CONTACT PHONE #: _____

DO YOU HAVE ANY MAJOR MEDICAL ISSUES? N Y IF YES, PLEASE EXPLAIN: _____
_____
_____

DO YOU HAVE ANY ALLERGIES? N Y IF YES, PLEASE EXPLAIN: _____
_____

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____ **PHONE:** _____

PATIENT SIGNATURE: _____ **DATE:** _____

BARIATRIC PATIENT MEDICAL HISTORY FORM

NAME: _____ AGE: _____ DOB: _____

SEX: Male Female How did you hear about us? _____
_____

PRESENT STATUS

Who is your Primary Care Physician? _____

May Dr. Kene Anamekwe communicate with your physician? Yes No
If "Yes", please provide a contact number: _____

When were your last labs drawn? _____

When was your last EKG? _____

1. Are you in good health at the present time to the best of your knowledge? Yes No
   If "No", please explain: _____

2. Are you under a doctor's care at the present moment? Yes No
   If "Yes", please explain: _____

3. Are you taking any medications (prescribed or over-the-counter) at the present time? Yes No
   If "Yes", please list ALL medications:
   Medications Dosage
   _____
   _____
   _____
   _____
   _____
   _____

4. Any allergies to ANY medications? Yes No
   If "Yes", please list all allergies: _____
   _____

5. History of High Blood Pressure? Yes No

6. History of Diabetes? Yes No
   If "Yes", at what age: _____

7. History of Heart Attack or Chest Pains or other heart conditions? Yes No

8. History of swelling feet? Yes No

9. History of frequent headaches/migraines? Yes No
If "Yes", please list medications for headaches: _____
_____

10. History of constipation (difficulty in bowel movements)? Yes No

11. History of Glaucoma? Yes No

12. History of Sleep Apnea? Yes No

13. History of Eating Disorder? Yes No
If "Yes", please explain: _____

14. Gynecological History
Pregnancies
Number: _____
Ages: _____
Natural Delivery or C-Section (specify): _____
Menstrual Cycles
Onset: _____
Duration: _____
Are they regular? Yes No
Pain associated? Yes No
Last menstrual period: _____
Hormone Replacement Therapy? Yes No
What? _____
Birth Control Pills? Yes No
Type? _____
Last check up? _____
Are you breast feeding? Yes No
Plan to become pregnant in the next 6 months? Yes No

15. Serious Injuries? Yes No
If "Yes", please list all and specify each injury and date:
_____
_____
_____
_____

16. Any surgeries? Yes No
If "Yes", please list all and specify each surgery and date:
_____
_____
_____
_____

17. Family History

	Age	Health	Disease	Cause of Death	Overweight
Father					
Mother					
Brother(s)					
Sister(s)					
Child(ren)					

Medical Review (Check all that apply)

____Gout	____Diarrhea	____Heart Palpitations	____Urine Frequency
____Fever	____Pneumonia	____Kidney Disease	____Heart Disease
____Cough	____Arthritis	____Liver Disease	____Psychiatric Illness
____Ulcers	____Headaches	____Lung Disease	____Alcohol Abuse
____Anemia	____Heartburn	____Night Sweats	____Blood Transfusion
____Thirst	____Depression	____Chicken Pox	____Erectile Dysfunction
____Cancer	____Congestion	____Rheumatic Fever	____Muscle Cramps
____Nausea	____Tuberculosis	____Bleeding Disorder	____Blood in Stool
____Anxiety	____Osteoporosis	____Nervous Breakdown	____Shortness of Breath
____Fatigue	____Constipation	____Thyroid Disease	____Burning with Urination
____Malaria	____Joint Pain	____Drug Abuse	____Heart Valve Disorder
____Jaundice	____Chest Pain	____Heart Disease	____Leg Pain with Walking
____Swelling	____Memory Loss	____Gallbladder Disorder	____Other_____
____Vomiting	____Scarlet Fever	____Eating Disorder	_____

Nutrition Evaluation

1. Present weight: _____ Height (no shoes): _____ Desired weight: _____
In what time frame would you like to be at your desired weight? _____

2. Birth weight: _____ Weight at 20 years of age: _____ Weight one year ago: _____

3. What is the main reason for your decision to lose weight? _____
_____
_____

_____

4. When did you begin gaining excess weight (Give reasons, if known)? _____
_____

5. What has been your maximum lifetime weight (non-pregnant) and when? _____
_____

6. Previous diets you have followed (give dates and results of your weight loss)
_____
_____
_____
_____

Have you tried appetite suppressants? Yes No
Which one(s)? _____
If "Yes", would you use them again? Yes No

Have you ever used Nutritional Supplements as part of weight loss programs? Yes No
If "Yes", would you use them again? Yes No

Would you like information about the products we carry in our center? Yes No

7. Is your spouse, fiancé or partner overweight? Yes No

8. By how much is he or she overweight? _____
Does he or she encourage your weight loss plan? Yes No

9. How often do you eat out? _____

10. What restaurants do you frequent? _____

11. How often do you eat "fast foods"? _____

12. Who plans meals?_____ Cooks?_____ Shops?_____

13. Do you use a shopping list? Yes No

14. What time of day and on what day do you usually shop for groceries?_____
_____

15. Food allergies_____

16. Food dislikes_____

17. Food(s) you crave_____
18. What specific time of day or month do you crave food?_____

19. Do you drink coffee or tea? Yes No How much daily?_____

20. Do you drink cola drinks? Yes No How much daily?_____

21. Do you drink alcohol? Yes No What?_____
    How much daily?_____ Weekly?_____

22. Do you use a sugar substitute?_____ Butter?_____
    Margarine?_____

23. Do you awaken hungry during the night? Yes No What do you do?_____
    _____

24. What are your worst food habits?_____

25. Snack habits
    What?_____
    How much?_____
    When?_____

26. When you are under a stressful situation at work or family related, do you tend to eat more?_____
    Explain_____
    _____

27. Do you think you are currently undergoing a stressful situation or an emotional upset?_____
    Explain_____

28. Smoking habits (answer only ONE)
    ____I have never smoked cigarettes, cigars or pipes
    ____I quit smoking ____ years ago and have not smoked since
    ____I have quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling smoke
    ____I smoke 20 cigarettes per day (1 pack)
    ____I smoke 30 cigarettes per day (1.5 packs)
    ____I smoke 40 cigarettes per day (2 packs)

29. Describe your usual energy level_____

30. What is your occupation?_____

31. Activity level (answer only ONE)
____Inactive – no regular physical activity with a sit-down job
____Light activity – no organized physical activity during leisure time
____Moderate activity – occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling
____Heavy activity – consistent lifting, stair climbing, heavy construction, etc…or regular participation in jogging, swimming, cycling or active sports at least three times per week
____Vigorous activity – participation in extensive physical exercise for at least 60 minutes per session, 4 times per week

32. What exercise do you enjoy?_____

33. List the exercise equipment or workout DVDs you have at home_____
_____

34. Are you a member of a gym or have a personal trainer?_____

35. Behavior style (Answer only ONE)
____I am always calm and easygoing
____I am usually calm and easygoing
____I am sometimes calm with frequent impatience
____I am seldom calm and persistently driving for advancement
____I am never calm and have overwhelming ambition
____I am hard-driving and can never relax

36. Please describe your general health goals and improvements you wish to make?_____

_____

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for taking the time to complete this comprehensive history form. It will give us the information to develop a plan specific to you.

*Please complete the following log with your current food choices. This will help us guide you to make healthier choices that fit your lifestyle. The more detailed you can be, the more information we will have to customize your plan.

**Typical Daily Food Log (1 day – minimum). Please include Meals, Snacks, Beverages and Estimate Portion Sizes

Time	Foods Eaten	Serving Size	Home/Restaurant

Again, it is not necessary to purchase any products from Vivify Wellness Center. Our commitment is to provide education to make a lifestyle change, not a diet. However, each client has different challenges when it comes to making better choices and the products we offer may make the transition into a healthy lifestyle easier. We will work as a team to build a program that is right for you.
Please check any of the tools you would like more information on during your initial visit. This is not a commitment but rather a request to receive further information on what we have available.

I would like information on:

____Appetite suppressants

____Meal replacement bars, shakes and/or soups for occasional use

____Jump Start Program – Most aggressive medical diet with 800 calorie per day meal replacement. Patients must qualify for the program based on BMI and risk factors. This requires weekly office visits and routine lab work.

Screening for Sleep Apnea
(Must be completed by ALL patients)

This short quiz is designed to help you to recognize possible sleep apnea so that you can realize that there can be relief for your symptoms. Please circle the number next to any that apply to you.

Yes	No	Do you wake up in the morning tired and foggy, not ready to face the day?
Yes	No	Do you have headaches in the morning?
Yes	No	Are you very sleepy during the day?
Yes	No	Do you fall asleep easily during the day?
Yes	No	Do you have difficulty concentrating, being productive and completing tasks at work?
Yes	No	Do you carry out routine tasks in a daze?
Yes	No	Have you ever arrived home in your car but couldn't remember the trip from work?
Yes	No	Have you ever fallen asleep at a stop light or stop sign?
Yes	No	If you doze off, do you sometimes wake up with a snort?
Yes	No	Are you having serious relationship problems at home, with friends and relatives or at work?
Yes	No	Are you afraid that you may be out of touch with the real world, enable to think clearly, losing your memory or emotionally ill?
Yes	No	Do your friends tell you that you are not like yourself?
Yes	No	Are you depressed?
Yes	No	Are you irritable and angry, especially first thing in the morning?
Yes	No	Are you overweight?
Yes	No	Do you have high blood pressure?
Yes	No	Do you have pains in your bones and joints?
Yes	No	Do you have trouble breathing through your nose?
Yes	No	Do you often have a drink of alcohol before going to bed?
Yes	No	If you are a man, is your collar size 17 inches (42 centimeters) or larger? 16 inches for a female?
Yes	No	Do you snore loudly at night?
Yes	No	Do you have frequent pauses in breathing while you sleep (you stop breathing for ten seconds or longer)?
Yes	No	Are you restless during sleep, tossing and turning from one side to another?
Yes	No	Does your posture during sleep seem unusual (do you sleep sitting up or propped up by pillows)?
Yes	No	Do you have insomnia (waking up frequently and without a reason)?
Yes	No	Do you have to get up to urinate several times during the night?
Yes	No	Have you wet your bed?
Yes	No	Have you fallen from bed?

How many "Yes" answers do you have? _____

If you answered "yes" to *any* of these questions, you *may* have sleep apnea. However, if you answered "yes" to any of the following especially important four questions, this *strongly suggests* that sleep apnea is the problem.

1 – are you sleepy during the day
2 – do you fall asleep easily during the day
3 – do you snore loudly each night
4 – do you have frequent pauses in breathing while you sleep

PERSONAL HEALTH QUESTIONNAIRE DEPRESSION SCALE (PHQ-9)
(Must be completed by ALL patients)

Over the **last 2 weeks**, how often have you been bothered by any of the following problems? (Circle **one** number on each line)

0 – None at all **1 –** Several days **2 –** More than half the days **3 –** Almost every day

1.	Little interest in doing things	0	1	2	3
2.	Feeling down, depressed or hopeless	0	1	2	3
3.	Trouble falling or staying asleep or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself, or that you are a failure, or have let yourself and your family down	0	1	2	3
7.	Trouble concentrating on things, such as reading or watching television	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed OR the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9.	Thoughts that you would be better off dead, or hurting yourself in some way	0	1	2	3