radius
returning the care factor

Form | New Patient – Your Healthy Body

Date:

Office Use Only:
Form Completed ☐ Staff Initial _____

YOUR HEALTHY BODY CLINIC

Initial Assessment

Mr / Mrs / Ms / Dr / Other _____ Date of Birth: _____

First Name: _____ Middle Name: _____

Surname: _____ Preferred Name: _____

Home: _____ Work: _____ Mobile: _____

Email: _____

Address: _____

Suburb/City: _____ Post Code: _____

Medicare Card No: _____

Ref No: Expiry Date:

Concession (please circle): Pension Veterans Healthcare Card Commonwealth Seniors Card None

Concession Card No: _____ Exp Date: _____

Private Health Insurance (please circle): Basic Hospital Intermediate Top Hospital None

Country of Birth _____ Language/s Spoken 1. _____

Ethnicity _____ 2. _____

Aboriginal / Torres Strait Islander? YES / NO Interpreter Needed: YES / NO

Who is your usual General Practitioner? _____

Suburb _____

Past Medical History: _____

_____

Previous Surgery: _____

_____

Medications: _____

_____

_____

Food Allergies: _____

Smoking YES / NO Occupation: _____

How did you hear about the clinic?

Patient of Radius GP Facebook Sign Google Our Website Brochure

Other Doctor/Specialist: Name: _____

Personal recommendation / by whom _____

Next of Kin / Who would we call in case of an Emergency?

Please circle: Mr / Mrs / Miss / Ms

First Name: _____ Surname: _____

Phone Number: _____ Relationship to the patient: _____

WEIGHT HISTORY

What is your heaviest (non-pregnant) weight? KG _____

What is your lightest weight? KG _____

What is your ideal weight? KG _____

Is there a family history of overweight or obesity? KG _____

What weight loss tools have you tried in the past? (Please tick all that apply)

- ☐ Jenny Craig
- ☐ Weight Watchers
- ☐ Lite N Easy
- ☐ Michelle Bridges Program
- ☐ Atkins Diet
- ☐ 5:2 Diet
- ☐ CSIRO Total wellbeing diet
- ☐ Keto Diet
- ☐ Mediterranean Diet
- ☐ Very Low Caloric Diet (VLCD) e.g. Optifast, Tony Ferguson, Kicstart
- ☐ Diet and Exercise
- ☐ Other _____

Medications:

- ☐ Phentermine (Duromine)
- ☐ Orlistat (Xenical)
- ☐ Sibutramine (Reductil)
- ☐ Topirimate (Topamax)
- ☐ Liraglutide (Saxenda)

Weight Loss Surgery:

- ☐ Gastric banding? When? _____ Surgeon? _____
- ☐ Sleeve gastrectomy? When? _____ Surgeon? _____
- ☐ Gastric bypass? When? _____ Surgeon? _____
- ☐ Other? _____

Do you have a history of eating disorders? (e.g. Anorexia, Bulimia) _____

PHYSICAL ACTIVITY

How active would you say you are currently?

- ☐ Extremely Inactive or immobile – You are seated for most or all of the day e.g. Wheelchair bound, inactive, couch board. Sedentary – Seated for extended periods throughout the day? e.g. Office Worker
- ☐ Moderately Active – You are an active and on the go kind of person e.g. Work in hospitality, childcare or run approximately 1 hour per day.
- ☐ Very Active – You do heavy manual labour for a job e.g. Builder, Labourer
- ☐ Extremely active – e.g. Competitive marathon runner

REASON FOR WEIGHT LOSS

Why do you want to lose weight? _____

_____

_____

READINESS FOR CHANGE

On a scale of 0-10, How *motivated* are you to control your weight?

0	1	2	3	4	5	6	7	8	9	10
Not at all motivated					Somewhat motivated				Extremely motivated	

On a scale of 0-10, how *ready* are you to make lifestyle changes to control your weight?

0	1	2	3	4	5	6	7	8	9	10
Not at all ready					Somewhat ready				Extremely ready	

On a scale of 0-10, how confident do you feel that you can manage your weight?

0	1	2	3	4	5	6	7	8	9	10
Not at all confident					Somewhat confident				Extremely confident	

On a scale of 0-10, how often do you feel stressed, anxious, or depressed?

0	1	2	3	4	5	6	7	8	9	10
None of the time					Some of the time				All of the time	

SLEEP

Do you have sleep apnoea? YES / NO If yes, My sleep physician is _____ (skip to next section)

On average, how many hours do you get per night? _____ Hours

Do you snore? _____

Has anyone told you that you stop breathing or have choking episodes overnight? _____

Do you wake up feeling unrefreshed or can you fall asleep easily during the day? _____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrasts to feeling just tired?

This refers to your usual way of life in recent times.

Even if you have not done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0 = would **never** doze
1 = **slight chance** of dozing
2 = **moderate chance** of dozing
3 = **high chance** of dozing

It is important that you answer each question as best you can.

Situation	**Chance of Dozing (0-3)**
Sitting and reading	
Watching TV	
Sitting inactive in a public place e.g. meeting, cinema	
As a passenger in a car for half an hour without a break. Lying down to rest in the afternoon when circumstances permit Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	

Thank you for your cooperation.

PATIENT CONSENT

At Your Healthy Body we are here to assist you achieving your weight loss goals.
We want you to know what we provide, and the costs involved.
We ask that you ready through this form carefully.

Your Consent

I, _____(first and last name) consent to the following:

By becoming a patient of Radius Medical Centre and signing this new patient form, I agree and consent to the following:

- ☐ I consent to the use of my personal health information by the Radius Medical Centre and other health care providers involved in my medical treatment and health care with this Centre.
- ☐ I consent to the disclosure of my personal health information by the above-named practice to other health care providers involved directly or indirectly in my personal health or medical treatment.
- ☐ I consent to receive follow up reminders and recalls sent via SMS or mail to my contract details are part of preventative health services offered by this practice when routine investigations are due.
- ☐ I understand that Schedule 8 scripts will not be prescribed at my initial appointment.
- ☐ I consent to the use of my personal health information in relation to Your Healthy Body being used for Practice Quality Assurance and Research.

Patient Signature: _____ Date: ____ / ____/ ____

FEES

A guideline of consultation fees are below:

General Practitioner

Initial consult	$170.00	**Rebate**	$76.95	**Out of pocket**	$93.05
Review consult short	$90.00	**Rebate**	$39.75	**Out of pocket**	$50.25
Review consult long	$170.00	**Rebate**	$76.95	**Out of pocket**	$93.05

Dietitian

Initial consult	$170.00
Review consult long	$90.00
Review consult short	$50.00

- If you have GPMP from your GP, you will be entitled to claim your allocated Dietitian appointments (stated on EPC from GP) through **Medicare. Rebate = $56.00.**
- If you have private health, you may be entitled to a rebate, this will need to be confirmed with your private health fund