Hatahet Center for Weight Management
3901 Highland Ste A, Waterford, MI 48328. Tel: (248) 681-2226 Fax: (248) 681-6494
M. Ammar Hatahet, MD, MPH, FACP, Clinical Professor, Michigan State University
hatahetcenter.com

NAME: ________________________________ Date of Birth: / / Male/Female

SSN:________________ Home Address ________________________ City _____________ Zip Code ______

Marital Status: • Single • Married • Divorced • Widowed • Separated

Home phone number ( ) ____- ______ . Cell phone ( ) ____- ______ . Work Number ( ) ____- ______ .

Employer_________________Employer Address__________________City ______________Zip Code ______

Spouse's or Guardian's Name: ______________________________ _ ________ Phone number ( ) ____- ______ .

Emergency contact **Name** and **Relationship**: _______________ _ _ _ _____ _ _ Phone number ( ) ____- ______ .

Who may we thank for referring you? ____

Who, if any, has your permission to share your medical information: __________________________________

Primary Insurance Information:

Name of Insured: ______________________________ Relationship to patient: Date of birth: / / .

Name of Employer: ____________________________ Work number ( )_____ - ______ .

Address of Employer: ____

Insurance Company: ____________________Group # ________________ Contract # __________________

Insurance Company address: ____

Copay: __________ $. Deductible: _________ $. How much has been used this year ____________ $.

Secondary Insurance Information:

Name of insured:______________________________ Relationship to patient: Date of birth: / / .

Name of Employer: ____________________________ Work number ( )_____ - ______ .

Address of Employer: ____

Insurance Company: ____________________ Group # ________________ Contract # __________________

Insurance Company Address: ____

____ ___/___/___

SIGNATURE OF PATIENT / GUARDIAN (please indicate relationship to patient) **DATE**

Acknowledgement of receipt of Notice of Privacy Practices

____ ___/___/___

SIGNATURE OF PATIENT / GUARDIAN (please indicate relationship to patient) **DATE**

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Medical History

Patient: ________________________________ Date of Birth: ____________ Date:

A) What brings you in today? ________________________

B) What medical conditions do you have?

1- ________________________ 3- ________________________ 5- ________________________

2- ________________________ 4- ________________________ 6- ________________________

C) Past surgeries and dates if known?

D) Family History

Mother: Living / Deceased Age: Sisters: Living / Deceased

Any medical conditions? Any medical conditions?

Father: Living / Deceased Age: Brothers: Living / Deceased

Any medical conditions? Any medical conditions?

E) Social History

Do you smoke cigarettes? NO / YES If yes, how much and for how long?

If no, if you have quit smoking, quit date? ___/___/______

Do you drink alcohol? NO / YES If yes, how much and how often?

Do you use marijuana or other recreational drugs? NO / YES

If yes, what? How much and how often?

F) Please check the box if you have recently experienced any of the following:

☐ Headache ☐ Dizziness ☐ Lightheadedness ☐ Numbness ☐ Tingling ☐ Decreased energy level

☐ Depressed mood ☐ Snoring ☐ Nausea ☐ Vomiting ☐ Constipation ☐ Diarrhea ☐ Black stools

☐ Chest pain ☐ Palpitation ☐ Cough ☐ Shortness of breath ☐ Frequent urination ☐ Dribbling

☐ Burning with urination ☐ Decreased sexual interest ☐ Decreased sexual performance

Other: ________________________

Patient Diet History Questionnaire

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Patient name:______________________________ **Date:**______________

Please complete the following statements by checking: Often, Sometime, Rarely or Never

	Often	Sometimes	Rarely	Never
1- I eat when I am not hungry.				
2- I feel hungry.				
3- I miss meals				
4- I eat when I am bored.				
5- I eat when I am stressed out.				
6- I eat high-fat snacks				
7- I eat large amounts of food at one time.				
8- I do feel that my eating is out of control at times.				
9- I feel guilty after eating too much				
10- I exercise.				
11- I feel depressed, sad, or blue.				
12- I have little interest in doing things.				
13- I eat fast food.				
14- I use butter or margarine regularly.				
15- I eat cheese or pizza regularly.				
16- I eat cookies, cakes, or candy regularly.				
17- I eat red meat, or cold cuts regularly.				
18- I eat nuts, chips, or dip regularly.				
19- I eat fruits and vegetables often.				

Check Yes, No, or Not Sure for the following statements:	Yes	No	Not sure
1. I have been overweight since childhood.			
2. I have lost some weight over the past few months			
3. It has been a problem for me to lose weight.			
4. I am very motivated to lose weight right now.			
5. There are uncontrollable stresses in my life.			
6. I know I can commit to exercise right now.			
7. I like being physically active.			
8. I have tried to throw up food after meals.			
9 . I have been sexually abused as a child.			
10. My family is very supportive of me losing weight			
11. I have been diagnosed with an eating disorder.			
12. I smoke cigarettes.			

Complete this statement:

I want to weigh about _______pounds, because_______________________

Last time I weighed that much was in the year ____________________.

In the past I tried the following to lose weight ____

My breakfast usually is ____

My lunch usually is ____

My dinner usually is ____

My favorite snack is ____

Patient Health Questionnaire

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:________________________ **DATE:**____________

Over the last *2 weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than 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
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 or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety 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 of hurting yourself	0	1	2	3
	add columns		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
Not difficult at all	______
Somewhat difficult	______
Very difficult	______
Extremely difficult	______

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