



PIONEER VALLEY WEIGHT LOSS CENTERS  
2 Medical Center Drive Suite 202  
Springfield, MA 01107  
(413) 205-1200 Fax (413) 205-1220  
[www.pvweightloss.com](http://www.pvweightloss.com)

PIONEER VALLEY WEIGHT LOSS CENTERS was developed to give you the support, guidance and inspiration you need to help you achieve your desired weight loss. Our team of experts will work with you and guide you in the achievement of your goals. Most importantly, we recognize that everybody is an individual and therefore our team strives to create an individualized evaluation and treatment plan for each of our patients.

Our multidisciplinary team approach is modeled after the most successful programs in the country. Each specialist of our team is committed to your success.

Prior to your visit, you will need to fill out **ALL THE INFORMATION** included in this packet. Packets that are not completed may result in delays of appointments or curtailment of your initial visit. Completeness of this packet is essential because our staff will use this information to get a better understanding of your current health conditions and weight loss goals.

You will begin with a comprehensive medical evaluation by our board certified bariatrician. Once the initial visit has been completed, you will be scheduled to see one of our nutrition and exercise specialists. Follow up visits with the bariatrician are often scheduled monthly. Visits with the nutrition and exercise specialist are usually in the early stages and consist of three visits in total. It is imperative that you keep these appointments since the appointments are reserved for you and you alone.

**Cancellations of appointments without 24 hours notice will result in a fee determined by the program. This fee for a missed appointment will be \$50 for a missed initial appointment and \$25 for a missed follow-up appointment. Keeping your appointments are essential for your success in weight loss.**

### MEDICAL EVALUATION

During your appointment with the bariatrician (weight loss physician) your personal medical history will be reviewed, your current medical condition will be evaluated and recommendations regarding an appropriate and safe approach for your weight loss program will be made.

### NUTRITIONAL AND ACTIVITY EVALUATION

When you meet with our nutrition and exercise specialist, your current diet and food choices will be evaluated. Based on the results of that evaluation, a personalized meal plan and approach to meals will be developed. The goal of this experience is to find a meal plan that will result in weight loss as well as help you learn lifelong healthy habits. In addition, your activity levels will be evaluated and a personalized activity plan will also be coordinated. The plan will be based on your strengths and limitations along with your goals. The portion of our program is NOT covered by insurance.

## METABOLIC EVALUATION

As part of our program, there will be an assessment of your metabolism. This portion of the program helps us determine the exact aspects of your nutrition and activities evaluation. The test is done separately and is often covered by your insurance. It will require you to sit quietly for 10-20 minutes and breathe into a tube in order to evaluate your metabolism. After this test, our team will have a better understanding of your metabolic needs.

The focus of PIONEER VALLEY WEIGHT LOSS CENTERS is to be able to assist you with your weight loss goals in either medical or surgical approaches.

**If medical approaches are your choice for weight loss**, our centers work with you diligently to help you understand the role of food, activity, and behavior in terms of successful weight loss. In addition, our bariatrician may choose certain medications that will assist you in your weight loss goals. Your current health and medications will be taken into consideration prior to prescribing any weight loss medications to assist you. Following the guidelines set up by our team of experts will best assist you in your weight loss goals.

**If surgical approaches are your choice for weight loss**, our centers work with selected teams of bariatric surgeons in the area. You will be referred to one of these surgical teams for evaluation if you are appropriate and interested in that approach. While you are awaiting surgery, you will remain with the PIONEER VALLEY WEIGHT LOSS CENTERS, working on dietary components, activity components and behavioral changes in order to prepare you for the safest and best surgical experience possible. You will also follow up with us after surgery to receive the education and care necessary for the best possible outcomes in both the short term and the long term.

Because it is extremely important for your health and well being, you must meet certain criteria prior to the intervention of surgery. These will be discussed at your initial visit with us.

Once you have completed these criteria, you will be scheduled for a pre-op evaluation which will include a comprehensive medical history and physical, baseline laboratory testing, an EKG and any other tests deemed necessary to prepare you for a safe surgical experience. In addition, you will meet with the surgeon of your choice on several occasions. He or she will also evaluate your health and preparedness for surgery.

*Thank you for choosing  
PIONEER VALLEY WEIGHT LOSS CENTERS  
to be your team for weight loss.*

**We hope your experience with us is all that you expect  
and we look forward to assisting you in achieving your goals.**

*-The Staff at  
PIONEER VALLEY WEIGHT LOSS CENTERS*



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NAME: \_\_\_\_\_

DOB    /    /    Age    Sex: M / F

*Thank you for taking the time to complete this health history. Your information will assist us in providing you with an individualized plan for your health care needs. The information on this form is confidential and will be viewed only by our physicians and staff.*

**Please fill out ALL of this form out prior to your first visit.**

Primary Care Physician / Provider \_\_\_\_\_

Referring Physician / Provider \_\_\_\_\_

***In regards to approaches to your weight loss***

**Please circle** your interest in your approaches to weight loss:

- 1 I am interested only in medical approaches; I have no interest in surgery
- 2 I would like to learn about surgery BUT have no interest at this time
- 3 I would like to learn about surgery AND I am interested in having surgery
- 4 I am already educated in surgery AND I am interested in having surgery
- 5 I have ***already seen a surgeon*** about surgical approaches to weight loss

Referring Surgeon \_\_\_\_\_



**PERSONAL MEDICAL HISTORY:**

**Please circle all that may apply to YOU:**

- High Blood Pressure
- Type II Diabetes
  - HbA1C Level:
- High Cholesterol/Dyslipidemia
- Heart Problems/ Cardio Vascular Disease
  - Testing for Heart Disease:
- Stroke/
- Obstructive Sleep Apnea
- Asthma
- Pulmonary Embolism
- Deep Venous Thrombosis (Blood clots)
- Cancer      TYPE:

- Gastroesophageal Reflux Disease
- Fatty Liver
- Cholelithiasis/ Gallstones
- Hernias
- Urinary Stress Incontinence
- Hypothyroid Disease
- Polycystic Ovarian Syndrome
- Infertility
- Degenerative/Osteo Arthritis
- Low Back Pain
- Fatigue

**OTHER MEDICAL CONDITIONS:**

**FAMILY HISTORY:**

**Please circle any that apply to YOUR FAMILY MEMBERS**

- Obesity
- High Blood Pressure
- Type II Diabetes
- High Cholesterol/Dyslipidemia
- Heart Disease
- Coronary Artery Disease
- Congestive Heart Failure
- Stroke
- Cancer
  - Type:

- Gastroesophageal Reflux Disease
- Hepatic Steatosis/ Fatty Liver
- Cholelithiasis/ Gallstones
- Hypothyroid Disease
- Polycystic Ovarian Syndrome
- Pulmonary Embolism
- Deep Venous Thrombosis/Blood clots
- Obstructive Sleep Apnea
- OTHER:

**PAST SURGICAL HISTORY:**

Please list any surgical procedures that you have had and the dates of the surgery

SURGICAL PROCEDURES:

DATES OF SURGERY:

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**SOCIAL HISTORY:**

MARITAL STATUS: Married Single Widow/Widower Divorced

Who lives with you at home? \_\_\_\_\_

CHILDREN (Y / N) if yes: AGES: \_\_\_\_\_

SMOKING (Y / N) \_\_\_\_\_ Amount per day \_\_\_\_\_ Years smoking \_\_\_\_\_

Did you smoke in the past? (Y / N) When did you quit? \_\_\_\_\_

ALCOHOL (Y / N) When was your last drink? \_\_\_\_\_

ILLICIT DRUG USE (Y / N) Present Drug Use: \_\_\_\_\_

Past Drug Use: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

HOBBIES/ENJOYMENT: \_\_\_\_\_

SPRITUALITY/FAITH/RELIGION: \_\_\_\_\_

**WEIGHT LOSS/ WEIGHT MANAGEMENT HISTORY**

**Current Weight (pounds):**

**Desired Weight:**

**Previous Weight Loss Programs and Weight Loss Medications:** Use additional paper if needed:

<b>PROGRAM or MEDICATION</b>	<b>DATES</b>	<b>WEIGHT LOSS</b>

**DIETARY / ACTIVITY PATTERNS:**

Who does the shopping at home? \_\_\_\_\_

Who does the cooking at home? \_\_\_\_\_

How many meals do you eat per day? \_\_\_\_\_

How many meals do you eat **per week** outside of the home? \_\_\_\_\_

Do you like Carbohydrate (Starches and Sweets) more than other foods? (Y / N)

To what extent do you enjoy activity: None Slightly Moderately Greatly

How many hours of watching TV / Computer time per day: \_\_\_\_\_ hours/day

**REVIEW OF SYSTEMS: Circle any of the following you experience now or within the past 6 months**

**General**

Fatigue, weakness, malaise  
Fever, chills, sweats or night sweats

**Skin**

Skin disease (eczema, psoriasis)  
Pigment or color change Rash  
Excessive dryness Excessive bruising

**Head**

Frequent/ severe headache  
History of head injury  
Dizziness/Vertigo

**Eyes**

Difficulty with vision; eye pain; double vision  
Redness, swelling, discharge  
Wear glasses or contact lenses  
History of cataract surgery/intraocular lens implant

**Ears**

Frequent ear infections; ringing; difficulty hearing

**Nose and Sinuses**

Frequent colds; sinus infections; nosebleeds  
Seasonal allergies

**Mouth and Throat**

Bleeding gums, frequent sore throats  
Difficulty swallowing; hoarseness; sour taste in mouth

**Neck**

Enlarged or tender lymph nodes; goiter

**Lungs**

Sleep apnea / CPAP Machine  
Asthma; emphysema; bronchitis; pneumonia; tuberculosis  
Chest pain with breathing  
Wheezing or noisy breathing  
Shortness of breath –  
Cough; Sputum (color, amount)

**Heart**

History of heart attack; other heart problems  
High blood pressure  
High cholesterol  
Chest pain  
Use more than 2 pillows sleeping

**Circulation**

Swelling in legs  
Coldness; numbness; tingling in hands or feet  
Varicose veins  
Pain in calf when walking  
History of blood clot in leg  
Ulcers on legs

**Stomach and digestion**

Difficulty swallowing; choking sensation  
Heartburn; If yes, when does it occur?  
Sour taste in mouth  
Nausea; vomiting blood  
Ulcer, liver or gallbladder disease  
Jaundice  
Appendicitis  
Recent change in bowel habits  
Blood in stool  
Constipation; diarrhea  
Rectal bleeding  
Hemorrhoids; fistula

**Urinary system**

Urinary incontinence; stress incontinence  
Kidney disease  
Blood in urine

**Males**

Prostate problems  
Penile or testicular pain  
Genital sores or lesions  
Penile discharge  
Hernia

**Females**

Age at menarche (first period)  
Premenstrual pain; severe cramps with period  
Menopause Age of onset:  
Last gynecological checkup/pap smear

**Bones and Joints**

Arthritis or gout  
Joint pain; stiffness; swelling  
Limitation of motion of joints  
Back pain or disk disease

**Nervous/Psychological System**

History of seizure disorder; stroke  
Memory problems  
Nervousness; anxiety; tremors  
Mood changes; depression  
Bipolar disorder; schizophrenia

**Hematological System**

Bleeding tendencies of skin, mucus membranes  
Excessive bruising  
Blood transfusions

**Endocrine System**

History of diabetes  
Excessive thirst, urination, appetite  
History of thyroid disease  
Intolerance to heat or cold

### The Epworth Sleepiness Scale

Please rate your SLEEPINESS using the following number scale in the blanks below and to the left:

- 0 = **Never** doze
- 1 = **Slight** chance of dozing
- 2 = **Moderate** chance of dozing
- 3 = **High** chance of dozing

For the following circumstances:

- \_\_\_ Sitting and Reading
- \_\_\_ Watching Television
- \_\_\_ Sitting inactive in a public place (i.e. theater, meeting, etc.)
- \_\_\_ As a passenger in a car for an hour without a break
- \_\_\_ Lying down to rest in the afternoon when circumstances permit
- \_\_\_ Sitting and talking to someone
- \_\_\_ Sitting quietly after a lunch without alcohol
- \_\_\_ In a car, while stopped for a few minutes in traffic

A total score of 10 or more suggests the need for further evaluation to determine the cause of excessive sleepiness. This is usually done with a SLEEP STUDY and will be discussed.

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PVWLC Provider Reviewing Information

Date Reviewed

**PIONEER VALLEY WEIGHT LOSS CENTERS  
CHRISTOPHER R. KEROACK, M.D.**

**AUTHORIZATION OF INFORMATION DISCLOSURE**

❖ Please list the family members or persons, if any, whom we may inform about your general medical condition, diagnosis including treatment, healthcare operations and payment.

❖ Please list the telephone number where you can receive calls about your appointments, test results or other healthcare information.

Home telephone#: \_\_\_\_\_

Other #s : \_\_\_\_\_

**\*\*\*\*Cell phones are not a secure and private line\*\*\*\***

❖ Can confidential messages (appointment reminders and changes, etc) be left on your telephone answering machine?

YES \_\_\_\_\_ NO \_\_\_\_\_

❖ Please list the family members or persons, if any, whom may pick up Prescriptions, lab slips or other healthcare information.

❖ Please indicate if you want all correspondence sent in a sealed envelope marked "CONFIDENTIAL"

YES \_\_\_\_\_ NO \_\_\_\_\_

Patient's name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Pioneer Valley Weight Loss Center  
Acknowledgement of Receipt of Notice of Privacy Practices

I \_\_\_\_\_ acknowledge that I have received a copy of  
(Name of Patient)  
PIONEER VALLEY WEIGHT LOSS CENTER's Notice of Privacy Practices. This  
notice describes how PIONEER VALLEY WEIGHT LOSS CENTER may use and  
disclose my protected health information, certain restrictions on the use and disclosure of  
my healthcare information, and rights I may have regarding my protected health  
information.

\_\_\_\_\_  
(Signature of Patient, or Personal Representative)

\_\_\_\_\_  
(Today's Date)

\_\_\_\_\_  
(Relationship to patient)

PIONEER VALLEY WEIGHT LOSS CENTERS: OFFICE FINANCIAL POLICIES

One of our goals at the Pioneer Valley Weight Loss Centers is to provide and maintain good physician-patient relationships. Letting you know in advance of our Financial Policies, allows for good communication and enables us to achieve this goal. Please read this document carefully. If you have any questions please do not hesitate to ask a member of our staff.

1. Upon arrival, please present your CURRENT INSURANCE CARD at every visit. This is verification of the correct insurance and consent to bill them on your behalf. If the insurance company that you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan.
2. If our physicians do not participate in your insurance plan, payment in full is expected at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.
3. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
4. Patient balances are billed immediately upon receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill.
5. If previous arrangements have not been made with our Finance Office, any account outstanding greater than 28 days will be charged a re-bill fee. Any balance over 60 days will be forwarded to a collection agency.
6. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and co-insurances.
7. **CO-PAYS ARE DUE AT TIME OF SERVICE.** A \$10 processing fee (or service fee) will be charged in addition to your co-pay if it is not paid at time of service or by the end of the next business day.
8. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure and what services are covered. **By signing below I acknowledge that if I do not have a referral from my Primary Care Physician \_\_\_\_\_ for today's visit, I may be held responsible for payment of services provided.**
9. We require **24 HOURS NOTICE FOR CANCELING APPOINTMENTS.** There is a \$25 charge for follow-up appointments and \$50 charge for initial new patient appointments if they are not cancelled with 24 hours notice
10. A \$25 fee will be charged for any checks returned for insufficient funds, PLUS ANY BANK FEES INCURRED.
11. We charge \$20 for Medical Record Copying.
12. If you have work forms or disability forms, etc. to be completed, there is a \$50 charge per form. Payment is due when the forms are dropped off. We have a 3-5 day turn around time for forms. If a form is needed before 3 days, there is an additional \$15 "rush" fee.
13. Not all services provided by our office are covered by every plan. Any service determined not covered by your plan will be your responsibility.

**I have read and understand the above Office Financial Policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.**

\_\_\_\_\_  
Patient Name(s)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Responsible Party member's Name/Relationship (Parent/Guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Responsible Party Member's Signature

\_\_\_\_\_  
Date