Welcome!

Thank you for reaching out to Charles River Weight Care in Northborough! We’re thrilled to be part of your weight loss journey. Here’s how you can get started:

1. **Forms and Resources**:

   Please fill out the Weight Intake Form before your appointment, included in this mail or also available on our website at **everwell360.com**. This helps us focus on you during the visit. You can bring it with you or send it through Patient Gateway.

2. **Antiobesity Medication Form**:

   Take a moment to review this form, included in this mail or also available on our website at **everwell360.com**. Being familiar with these medications will help you feel more confident about your options.

3. **Insurance Check**:

   It’s helpful to check with your insurance company or HR department about which weight loss medications are covered. This info will streamline your treatment plan.

4. **Medication list**: To ensure we have accurate and up-to-date information on your medications, please bring a complete list of all medications you are currently taking.

We’re excited to offer the SECA mBCA 554, a state-of-the-art body composition analyzer. This optional but highly recommended tool provides detailed insights into your body composition, including fat mass, muscle mass, and hydration levels. These metrics can help us tailor your weight management plan more effectively.

**Follow-Up Schedule:**

* **Monthly Visits**: Regular check-ins are key to staying on track, so we typically schedule these monthly.
* **Maintenance Phase**: Once you’ve reached your goals, we’ll move to visits every 12 weeks to help you maintain your success.
* **Virtual Visits**: We also offer virtual follow up visits after the initial consultation for your convenience, making it easy to stay connected with your care team even when traveling or managing a busy schedule.

We can’t wait to meet you and support you every step of the way!

Warm regards,

Gunardi Irawan, MD, DABOM

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## Weight Intake Form

**Welcome! To customize a plan just for YOU, it helps us to have some more details.**

**Please fill out this questionnaire before your visit so we can make the most of our time together.**

### Weight History

What has your weight been like over time? Draw a chart. Note anything you feel has been significant to help you lose weight or reasons you might have gained weight.

Weight

Year or Event

**WHY do you want to lose weight?**

**Have there been things that have helped you lose weight in the past?**

**Have you ever participated in any formal diet programs (e.g. Noom, Weight Watchers, Jenny Craig)? If so, when/how long?**

**Do you have times when you eat more than you plan and feel out of control? If so, how often?**

**Please answer “yes” or “no”.**

Do you snore?

Do people tell you that you stop breathing in your sleep?

Do you have headaches in the morning?

Are you constantly sleepy?

Can you fall asleep anywhere?

**Are you interested in medications to help you lose weight?**

Not Interested Very Interested

1 2 3 4 5 6 7 8 9 10

**How confident are you that you will be able to lose weight?**

Not Confident Very Confident

1 2 3 4 5 6 7 8 9 10

### What does a typical day of eating look like for you?

Breakfast:

Snacks:

Lunch:

Snacks:

Dinner:

Snacks:

Drinks:

What about weekends and special occasions?

How often do you get fast food or eat out at restaurants?

What type, if any, exercise do you currently do?

### Are there any foods you CANNOT eat?

|  |  |  |
| --- | --- | --- |
| **To better guide us to choose weight loss medication options, do you have? (Y/N)** | | |
|  | **Y** | **N** |
| History of heart disease? |  |  |
| History of glaucoma? |  |  |
| Intolerance to caffeine/stimulants? |  |  |
| Anxiety? |  |  |
| History of kidney stones? |  |  |
| History of severe migraines? |  |  |
| History of depression? |  |  |
| History of seizures? |  |  |
| Any tobacco use? |  |  |
| Uncontrolled hypertension? |  |  |
| Any recreational drug use? |  |  |
| Currently taking opioids (e.g. morphine, hydrocodone) or have any upcoming procedures/surgeries? |  |  |
| Any alcohol intake? (How much per week) |  |  |
| History of diabetes, prediabetes, or gestational diabetes? |  |  |
| History of pancreatitis or gallbladder disease? |  |  |
| History or Family History of thyroid cancer? |  |  |
| History or Family History of endocrine neoplasia? |  |  |
| General fear of needles or self-injections? |  |  |
| Currently pregnant or attempting to conceive? |  |  |
| Breastfeeding? |  |  |
| If sexually active, are you using contraception? |  |  |

**Insurance Coverage for Weight Loss Medications:**

*Please contact your insurance plan and inquire if it covers any of the following weight loss medications. (Please circle all that apply)*

* Zepbound
* Wegovy
* Mounjaro
* Ozempic
* Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_