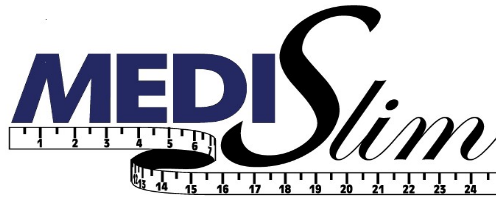
1901 LAFAYETTE ROAD, STE 100
CRAWFORDSVILLE, IN 47933



PHONE: (765) 362-SLIM
FAX: (765) 364-8641

EXPERT WEIGHT MANAGEMENT

ARUN JAIN, MD, FACOG

INITIAL APPOINTMENT INSTRUCTIONS AND PROCEDURES

Please Review Carefully Prior to Your First Visit

Welcome to our practice! We are excited you have decided to join our program. Our staff is committed to helping you reach your weight loss and fitness goals. Along with your hard work and determination, we hope to motivate you to success. Below you will find instructions for your initial consultation.

APPOINTMENT TIME: ____

24-Hour Notification Required To Reschedule Your Appointment or You Will Forfeit Your $50 Deposit

1. Your enrollment materials must be filled out completely before you come to your appointment.

2. Be sure to be fasting 6 hrs. prior to your appointment. You will need to be prepared to get you blood drawn at our in-office site.

3. When you come to your appointment, please first check-in at the window. You will be asked for your black binder and to pay your $245. We accept cash, check, debit and charge cards.

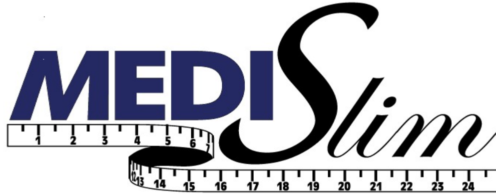
4. We will take your picture, height, weight, blood pressure, EKG, measurements, and body composition testing.

5. You will meet with Dr. Jain who will discuss your weight loss and health history, do a brief physical exam, and review your body composition results.

6. At your first return visit, Dr. Jain will outline his recommendations for your own weight loss program based on the result of your blood tests, health history, and body composition results at which time medication will be dispensed.

7. You will follow-up on a weekly basis to check weight, blood pressure, and symptoms and to make any changes in your program. Please see separate information about guidelines for weekly visits.

8. Please let us know how we can make your experience a positive one!



Patient Information Form

Patient Name: (Last)______________________________(First)____________________________(MI)___

Name you prefer to be called: ____

Patient Address: ____

City: ____ State: ______________ Zip: ________________

Home Phone: ___________________________________Cell Phone: ________________________

Birthdate: _______________________________________Age: _________Sex: M F

Social Security: __________________________________ E-mail:_________________________________

Education: Elementary High School/Technical School 2-yr College 4-yr College Graduate School
(Circle the highest level achieved)

Employment Information:

Patient Employer: _______________________________ Occupation: ______________________________

Employer Address: ____

City: ____ State: ______________ Zip: ________________

Work phone No: __________________________________Ext. _____________________________________

In Case of Emergency:

Name: __________________________________Relationship: _______________ Phone: ______________

Patient's Spouse: ____ Phone: ______________

Family Physician: ____ Phone: ______________

Referred by: ____

Financial Policy:

Thank you for selecting Arun Jain, MD FACOG for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered. For your convenience, we accept cash, personal checks, and credit cards.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

____ ____

Patient's Signature Date

Medical History Form

Name: ____ Age:_________ Sex: M F

Family Physician: ________________________

Present Status:

1. Are you in good health at the present time to the best of your knowledge? Yes No

2. Are you under a doctor's care at the present time? Yes No
   If yes, for what? ____

3. Are you taking any medications at the present time? Yes No
   What: ______________________________________ Dosages: __________________
   What:______________________________________ Dosages: __________________

4. Any allergies to any medications? Yes No
   ____

5. History of High Blood Pressure? Yes No

6. History of Diabetes? Yes No
   At what age: ____________

7. History of Heart Attack or Chest Pain? Yes No

8. History of Swelling Feet Yes No

9. History of Frequent Headaches? Yes No
   Migraines? Yes No Medications for Headaches: ____________________________

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

11. History of Glaucoma? Yes No

12. Gynecologic History:
    Pregnancies: Number: ________________ Dates: ____________________________
    Natural Delivery or C-Section (specify): _____________________________________
    Menstrual: Are they regular: Yes No
    Last menstrual period: ____
    Contraception: ____
    Hormone Replacement Therapy: Yes No
    What: ____
    Birth Control Pills: Yes No
    Type: ____
    Last Check Up: ____

13. Serious Injuries: Yes No
    Specify: ____ Date: ________

14. Any Surgery: Yes No
    Specify: ____ Date: ________
    Specify: ____ Date: ________

15. Family History:

	Age	Health	Disease	Cause of Death	Overweight?
Father:					
Mother:					
Brothers:					
Sisters:					

Has any blood relative ever had any of the following:

Glaucoma: Yes No Who: ______________________________

Asthma: Yes No Who: ______________________________

Epilepsy: Yes No Who: ______________________________

High Blood Pressure Yes No Who: ______________________________

Kidney Disease: Yes No Who: ______________________________

Diabetes: Yes No Who: ______________________________

Heart Disease/Stroke Yes No Who: ______________________________

Past Medical History: (check all that apply)

_______ Jaundice

_______ Lung Disease

_______Stomach Ulcers

_______ Thyroid Disease

_______Heart Disease

_______ Drug Abuse

_______ Cancer

_______ Osteoporosis

_______ Kidney Disease

_______ Rheumatic Fever

_______ Gout

_______ Anemia

_______ Gallbladder Disorder

_______ Anorexia or Bulimia

_______ Blood Transfusion

_______ Other: ______________

_______ Liver Disease

_______ Bleeding Disorder

_______Nervous Breakdown

_______ Heart Valve Disorder

_______ Psychiatric Illness

_______ Alcohol Abuse

_______ Arthritis

Nutrition Evaluation:

1. Present Weight: __________ Height (no shoes): ___________ Desired Weight: _____________

2. In what time frame would you realistically like to be at your desired weight? _____________________

3. Birth Weight: _____ Weight at 20 years of age: ___________ Weight one year ago: _______________

4. What is the main reason for your decision to lose weight? ______________________________

5. When did you begin gaining excess weight? (Give reasons, if known): ______________________________
____

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

7. Previous diets you have followed: ______________________________ ______________________________

Give dates and results of your weight loss: ______________________________ ______________________________

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

9. By how much is he or she overweight? ______________________________

10. How often do you eat out? ______________________________

11. What restaurants do you frequent?______________________________

12. How often do you eat “fast foods?”______________________________

13. Who plans meals? ______________________ Cooks? ____________________ Shops? ______________

14. Do you use a shopping list? Yes No

15. What time of day and on what day do you shop for groceries? ________________________________

16. Food allergies: ____

17. Food dislikes: ____

18. Food you crave: ____

19. Any specific time of the day or month do you crave food? ___________________________________

20. Do you drink coffee or tea? Yes No How much daily? ___________________________________

21. Do you drink cola drinks? Yes No How much daily? ___________________________________

22. Do you drink alcohol? Yes No

What? __________________________ How much? ________________________ Weekly? _____________

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 thing you are currently undergoing a stressful situation or an emotional upset? Explain:

____

____

28. Smoking Habits:

____ You have never smoked cigarettes, cigars or a pipe.
____ You quit smoking _____ years ago and have not smoked since.

How much do you smoke now?
____ You smoke 20 cigarettes per day (1 pack).
____ You smoke 30 cigarettes per day (1-1/2 packs).
____ You smoke 40 cigarettes per day (2 packs).

29. Typical Breakfast Typical Lunch Typical Dinner

_________________________ _____________________ ____________________________
_________________________ _____________________ ____________________________

______________________	___________________	_________________________
______________________	___________________	_________________________
Time eaten: _____________	Time eaten: _________	Time eaten: _______________
Where: _________________	Where: _____________	Where: ____________________
With whom: ____________	With whom: _________	With whom: _______________

30. Describe your usual energy level: ____

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. Please mark the activities that you enjoy participating in.

____Walking
____Jogging
____Running
____Biking Outdoors
____Biking Indoors
____Weight Lifting
____Group Fitness Classes
____Fitness Videos at Home

33. Is there any activities that you would enjoy participating in but feel like you are physically unable to?

____

34. Behavior style: **(answer only one)**

____ You are usually calm and easygoing.

____ You are seldom calm and persistently on the go.

____ You are hard-driving and can never relax.

35. 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 your time and patience in completing this form.

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EXPERT WEIGHT MANAGEMENT

ARUN JAIN, MD, FACOG

Patient Informed Consent for Appetite Suppressants

I. Procedure and Alternatives:

1. I, ____ (patient or patient's guardian) authorize Dr. Arun Jain to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to, the use of appetite suppressants for more than 12 weeks and when indicated in higher doses than the dose indicated in the appetite suppressant labeling.

2. I have read and understand my doctor's statements that follow:

"Medications, including the appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter term studies (up to 12 weeks) using the dosages indicated in the labeling.

"As a bariatric weight loss physician, I have found the appetite suppressants helpful for periods far in excess of 12 weeks, and at times in larger doses than those suggested in the labeling. As a physician, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer term studies and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses.

"Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects (as noted below).

"As a bariatric physician, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant use for longer periods of time and when indicated in increased doses.
However, you must decide if you are willing to accept the risks of side effects, even if they might be serious, for the possible help the appetite suppressants use in this manner may give."

3. I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.

4. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.

5. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an exchange eating program without the use of the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

II. Risks of Proposed Treatment:

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks and in higher doses than the dose indicated in the labeling involves some risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heart beat and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

III. Risks Associated with Being Overweight or Obese:

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am.

IV. No Guarantees:

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that I will have to continue watching my weight all of my life if I am to be successful.

V. Patient's Consent:

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

WARNING

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK DR JAIN AT YOUR APPOINTMENT.

DATE:___________________________________ **TIME:**____________________________________

PATIENT:____

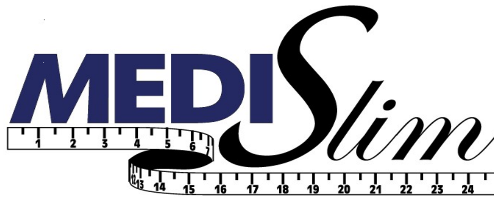
(or person with authority to consent for patient)

VI. PHYSICIAN DECLARATION:

I have explained the contents of this document to the patient and have answered all the patient's related questions, and, to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies and the risks of continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving the appetite suppressants in the manner indicated above.

____

Physician's Signature



EXPERT WEIGHT MANAGEMENT

ARUN JAIN, MD, FACOG

1901 LAFAYETTE ROAD, STE 100
CRAWFORDSVILLE, IN 47933

PHONE: (765) 362-SLIM
FAX: (765) 364-8641

Weight Loss Program Consent Form

I ____ authorize Dr. Arun Jain and whomever he designates as his assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, lifelong condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask Dr. Jain at your appointment.

Date: ____________________________________ **Time:** ____________________________________

Patient: ____

(Or person with authority to consent for patient)

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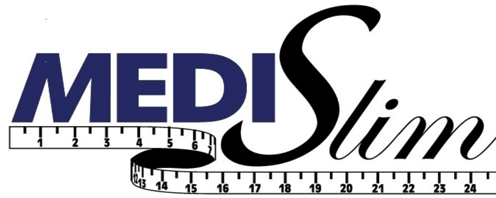

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EXPERT WEIGHT MANAGEMENT

ARUN JAIN, MD, FACOG

12 Reasons

"Why I Want to Reach My Goal Weight"

Name: ____ **Date:** __________________________________

Before writing your reasons down, give them some thought. It is important that these 12 reasons be true personal goals and desires. They should not be generalizations or what you think would please others because they will be used as your "personal motivator."

Take a few moments from time to time each day to thoughtfully read through this list. This is called mental programming. We suggest that you transfer your list onto a 3 x 5 card which may be more convenient.

Make a promise to yourself now: "I will read the entire card whenever I am confronted with a difficult food situation." Reading the list will clearly reinforce your personal commitment to take control of your health and self-esteem.

1. ____

2. ____

3. ____

4. ____

5. ____

6. ____

7. ____

8. ____

9. ____

10. ____

11. ____

12. ____

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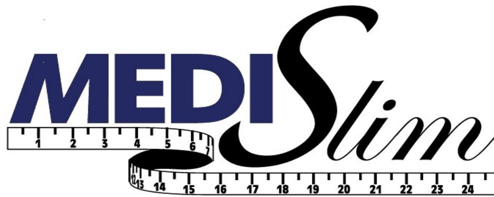

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Arun Jain, MD, FACOG
Expert Weight Management

Arun Jain, MD, FACOG

GUIDELINES FOR WEEKLY VISITS

This list is to help ensure that the weekly visits run smoothly for everyone. Please follow these conditions so we may serve you better. Thank you.

1. Please be sure to bring your black book and medicine bottles with you to every appointment. You will not be seen if you do not have both of these with you.

2. Every patient must be seen by Dr. Jain at least every 4 weeks in order to continue the program and medications. He will be happy to see you at any or all of your visits.
   Dr. Jain will be available for follow-up appointment on Wednesdays from 8:30 a.m. to 1:00 p.m. and 2:00 p.m. to 6:00 p.m. If you are struggling or think you need an adjustment in your diet or medications, you must come in during his available times.

3. The MediSlim staff will be available for follow-up appointments on Wednesdays from 8:30 a.m. to 1:00 p.m and 2:00 p.m. to 6:00 p.m. The nurses will try to remind each patient of the week they will need to see Dr. Jain and you will need to plan ahead to ensure your appointment with Dr. Jain will correspond to your scheduling needs.

4. If you are going on vacation, please be sure to let us know when you check-in the Wednesday prior and we will fill your medications for 2 - 3 weeks. The charge will be $80 for 2 weeks and $120 for 3 weeks. We will not be able to fill your medications for more than 3 weeks at a time.

5. For ease of flow, please pay as you check-out. Please keep your cash &/or check with you and not in your book to ensure it will not get lost between check-in and check-out.

6. If you need to use the restroom, please do so before being called back so there will not be a delay.

7. After you have reached your goal weight, you may start the maintenance program and only come once a month for $40 a month. This is not a requirement but highly recommended in order to maintain your weight.

8. If you drop out of the program for awhile and decide that you need to come back, you may do so if it has not been over a year since your last visit. Otherwise, you will have to start from the beginning. The only exception to this rule is if you were pregnant in that time, then you may have 2 years.

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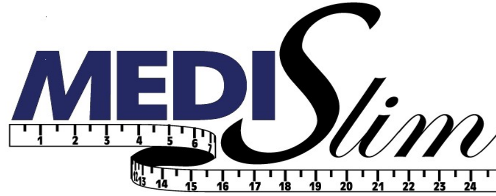

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Expert Weight Management

Arun Jain, MD, FACOG

Quick View of Available Appointments

Weekly Follow-up:	Wednesdays	8:30 a.m. to 1:00 p.m. 2:00 p.m. to 6:00 p.m.
Follow-up with Dr. Jain:	Wednesdays	8:30 a.m. to1:00 p.m. 2:00 p.m. to 6:00 p.m.

Our phone number is (765) 362-SLIM (7546) and press option #4 to leave a message. The staff at MediSlim strives to meet the needs of every patient. We hope to accommodate everyone's busy schedule and provide flexibility for emergencies. The entire staff at MediSlim values your time and effort and is dedicated to helping you achieve your health and fitness goals. If you need any assistance, please let one of us know.

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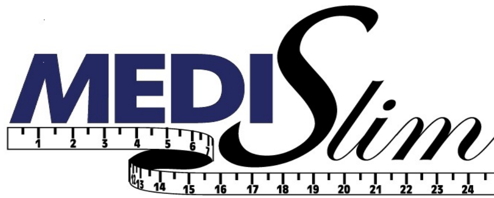

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EXPERT WEIGHT MANAGEMENT

ARUN JAIN, MD, FACOG

SUPPLEMENT MENU

These products are offered to everyone on the program. They are not required for your diet, but are just supplements for those who need it. **Each of these supplements offer 2 protein exchanges each or 4 protein and 1 milk exchange for 2 in a day.**

PROTEIN BARS
(These are $1.50 ea. Or 7 for $10.00)
Cinnamon Crunch Bar
Peanut Butter Cup
Lemon
Fluffy Nutter
Nutty Carmel Crunch
Vanilla Crisp
Salted Toffee Pretzel
Strawberry Shortcake

Soy Snacks
(These are $1.50 ea. Or 7 for $10.00)

Carmel Soy Snacks

Shakes
($2.00 each)
Chocolate Salted Carmel
Chocolate
Vanilla
Strawberry

CHIPS
(These are $1.50 ea. Or 7 for $10.00)
Honey Mustard Bites
Cheddar Bites
Pizza Bites
Nacho
BBQ

WAFERS(2 wafers per package)
(These are $1.50 ea. Or 5 for $10.00)
Vanilla
Mocha
Chocolate

Raspberry

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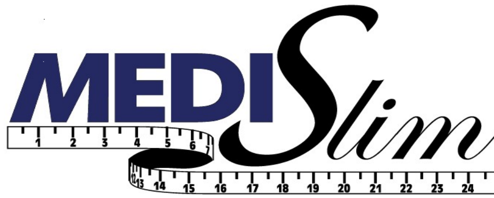

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Expert Weight Management

Arun Jain, MD, FACOG

Emergency Care

In the event of an emergency or severe symptoms while on our weight loss program you must proceed to the nearest emergency room for evaluation and treatment. These symptoms include chest pain, severe lightheadedness or dizziness, fainting, difficulty breathing, or severe abdominal pain. You should take any medications you are on with you. The ER physician may call Dr. Jain for further information.

If you have minor symptoms or questions you may call the MediSlim phone number (765-362-7546) and your call will be returned within 24 hours. We ask that you please reserve questions or concerns that are not urgent for the weekly follow-up visits.