

Personal Coaching Program

Our personal lifestyle coaching program offers trained coaches to provide additional support for your lifestyle change efforts at home.

Encouragement, accountability, and support are key elements of this coaching model. This program will help you make lasting changes for long-term success. You will receive a 20-minute telephone call every other week, as well as email support for the duration of your coaching program.

Check one:

- 3 month package** Or **6 month package**
\$295.00 **\$535.00**

Personal coaching fees are non-refundable.

For more information, call us at 1-800-235-3853
or email DFCINFO@mc.duke.edu
www.dukedietcenter.org



804 W. Trinity Ave., Durham NC 27701

PR562 3/01/07



New Client Application Form

Please complete the following application and return either by mail or fax (919) 684-8246 to our DFC admissions coordinators. Your application will then be reviewed to determine your eligibility for the program. You will receive notification of our decision within two business days after receipt of your application. We ask that you delay making travel or lodging arrangements, until after you have received confirmation of your program acceptance.

Contact Information:

Title: Mr. Mrs. Miss Ms. Dr. Other

Gender: Male Female

Marital Status: Single Married Separated Divorced Widowed

First Name / Middle Initial / Last Name Sr. Jr. III IV

Preferred Name

Social Security Number

Date of Birth: Month/Day/Year

E-mail / please format as username@email.com

Home address

City / State / Province / Zip Code / Country

Home Phone

Other Phone: cell beeper fax

Please complete the following information.

Occupation

Do you prefer to be contacted at home or at work?

home work

Work Phone

Work E-mail

Emergency Contact

Phone

Primary Physician's Name

Physician's Address

City / State / Province / Zip Code / Country

Office Phone

Office Fax

Are there other physicians who are closely involved in your medical care?

1. Physician's Name and Specialty

Physician's Address

City / State / Province / Zip Code / Country

2. Physician's Name and Specialty

Physician's Address

City / State / Province / Zip Code / Country

16. In order to provide you with the best possible care, we may need to speak with your mental health providers prior to your acceptance into the program. Please sign below to indicate your permission to do so.

Signature: _____

The DFC menu offers a wide variety of choices. However, occasionally we are not able to accommodate a dietary need. A DFC dietician will screen this form, and you will receive a phone call if you indicate special needs that might make it difficult for you to eat at the DFC.

Please check any of the following that apply, indicate the extent to which you adhere to these dietary guidelines and what foods you are not able to eat.

Vegetarian (avoid some animal products): _____

Vegan (avoid all animal products): _____

Kosher: _____

Food Allergies: _____

Other special dietary needs: _____

17. Other special needs: _____

If you have been hospitalized or have seen a doctor for significant problems within the past two years, or if you have medical records that may be helpful to the DFC medical staff, please bring copies for our review. Stress test results or the results of other heart or lung function studies, hospital discharge summaries, recent lab work, summaries of your current medical problems, and a complete listing of your prescriptions will be particularly helpful.

11. Have you ever vomited, used laxatives, or exercised excessively to compensate after overeating?
 Yes No If yes, when was the last time?: _____

12. Has anyone ever told you that you might have bulimia or anorexia?
 Yes No If yes, please explain: _____

13. Do you believe, or has anyone else told you, that you might have a problem with drug or alcohol use?
 Yes No If yes, please explain: _____

14. Name, dosage, and frequency of ALL prescription medications you are currently taking. _____

15. Have you ever been diagnosed with or treated for a psychological or emotional problem? Yes No If yes, please describe:

- How and when were you treated for this problem? Check all that apply and please list approximate dates and places for treatment, the names and contact information for recent providers, and a brief description of treatment.
- Outpatient psychotherapy/counseling

- Psychiatric hospitalization

- Other

Reservation Information:

Preferred admission date (Sunday dates only)

1st Choice: _____ 2nd Choice: _____

Program length: 5 days Two weeks Three weeks Four weeks

If more than four, please indicate the number of weeks(max. of 12 weeks) _____

Are you joining the program with anyone else? Yes No

If yes, give name: _____

Will this person be: full program participant

attending as a support person only

Please see the criteria for support participants at the following site www.dukedietcenter.org or call for information (1-800-235-3853).

How do you wish to secure your reservation? (\$500.00 deposit required)

Visa Mastercard American Exp. Discover Check Money Order

Credit Card No: _____ Exp. Date: _____

Name as on card: _____

If accepted to the program, where will you be staying?

How did you learn about our Center? _____

From a DFC graduate (name) _____

Doctor (name) _____ Personal Reference (name) _____

Advertisement (publication name) _____

Web search engine (name) _____

Other _____

Have you read or heard about any of our DFC Research? Yes No

Medical Information:

Your approximate weight in pounds or kilograms: _____

Your height in feet and inches or centimeters: _____

1. Have you been hospitalized for any reason in the past year?

Yes No If yes, please explain: _____

2. Personal history of cardiovascular disease (i.e. have you had heart attack, stroke, transient ischemic attack or TIA, coronary artery bypass or CABG, angioplasty, stent placement, aortic aneurysm, peripheral vascular disease, angina, or chest pain with exertion)?

Yes No If yes, please explain: _____

3. Have you had cardiac functional testing (i.e. stress electrocardiogram, exercise tolerance test, or “treadmill” test, stress echocardiogram, nuclear cardiology test) within the past year?

Yes No If yes, what test: _____

Please indicate results if known. **Please fax results to the medical clinic at 919-688-8022. Also, please be sure to bring a copy with you to the DFC.**

Normal Abnormal Unknown

4. Do you have heart disease other than those listed in #2 above (for example, valve damage, rhythm disturbance, congestive heart failure)?

Yes No If yes, please describe: _____

5. Do you have diabetes?

Yes No Don't know

6. Do you use tobacco products on a daily basis?

Yes No If yes, please explain: _____

7. Do you have high blood pressure or are you being treated for high blood pressure?

Yes No Don't know

8. Do you have abnormal blood lipids (i.e. total cholesterol, triglycerides, HDL cholesterol, or LDL cholesterol)? or do you take cholesterol-lowering medication?

Yes No Don't know

9. Have either of your parents or a sibling (brother/sister) had blood vessel disease (heart attack, coronary artery bypass surgery, angioplasty, stent, aortic aneurysm, peripheral artery disease, stroke, transient ischemic attack, or TIA) **at a young age** (i.e. father or brother before age 55, mother or sister before age 65)?

Yes No If yes, please describe the problem and the approximate age it occurred: _____

10. Do you need assistance walking, climbing stairs, or getting out of a chair?

Yes No If yes, please explain: _____
