



Application Form

Please complete the following application and return either by mail, e-mail (dfcapps@mc.duke.edu), or fax (919-688-3295) to our DFC Business Office. 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.

I am a ...

- New client Return client (within the last 5 years) Return client (more than 5 years since my visit)

Contact information

Legal name: _____ Mr. Mrs. Ms. Dr.

Nickname: _____ Gender: Male Female

Date of birth: _____ E-mail: _____

Home address: _____

City: _____ State: _____ ZIP: _____

Home phone: _____ Mobile phone or pager: _____

Occupation: _____

Work phone: _____ Work e-mail: _____

Where do you prefer to be contacted? At home At work Other: _____

Marital status: Single Married/Living with partner Separated Divorced Widowed

Emergency contact: _____ Phone: _____

Relationship: _____

Physician information

Primary care physician: _____

Address: _____

City: _____ State: _____ ZIP: _____

Office phone: _____ Office fax: _____

Please list any other physicians who are closely involved in your medical care:

Name and specialty: _____

Address: _____

City: _____ State: _____ ZIP: _____

Name and specialty: _____

Address: _____

City: _____ State: _____ ZIP: _____

Name and specialty: _____

Address: _____

City: _____ State: _____ ZIP: _____

Medical information

Your approximate weight: _____ Your height: _____ Have you been hospitalized in the last year? Yes No

If yes, please explain: _____

Name, dosage, and frequency of all prescription medications you are currently taking:

Do you have any personal history of heart disease?

- | | |
|--|--|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Aortic aneurysm |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Peripheral artery disease (PAD) |
| <input type="checkbox"/> Transient ischemic attacks (TIAs) | <input type="checkbox"/> Chest pain with exertion |
| <input type="checkbox"/> Coronary artery bypass or other heart surgery | <input type="checkbox"/> Heart failure |
| <input type="checkbox"/> Angioplasty/Stent placement | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cardiac arrhythmia/Irregularity of heartbeat | |

If you checked any of the above, please briefly detail:

Have you had a test of heart function during exertion in the last year? Examples are exercise tolerance test, treadmill test, stress echocardiogram, and nuclear cardiology test. (A resting EKG or a resting echocardiogram is **not** sufficient.)

If yes, were your results: Normal Abnormal Unknown

If accepted, you will need to fax any formal test results/interpretation to the medical clinic before your arrival at the DFC. If the formal test report is not available at the time of your intake assessment at the DFC, or if the findings are abnormal, your clearance for exercise may be delayed and additional testing may be required. Please fax the formal test interpretation to the medical clinic at 919-688-8022 in advance of your visit. Also, bring a copy with you to the DFC.

Do you have diabetes? Yes No Don't know

Within the last year, have you used tobacco products on a daily basis? Yes No

Type: _____ How much: _____

Do you still currently use this product? Yes No

How much alcohol do you typically consume in one week? _____

Do you have high blood pressure, or are you being treated for high blood pressure? Yes No Don't know

Do you have abnormal blood lipid levels (total cholesterol, triglycerides, HDL cholesterol, LDL cholesterol), or do you take medication to lower cholesterol? Yes No Don't know

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, or TIA) at a young age (father or brother before age 55, mother or sister before age 65)?

Yes (please list the disease and age of occurrence): _____ No

In order for us to ensure that you can benefit fully from the DFC Program, we must be aware of any special needs. Please indicate below any areas where you anticipate that you might have difficulty or may need assistance or accommodations:

- | | |
|---|--|
| <input type="checkbox"/> Getting in or out of: car van chair (circle all applicable) | <input type="checkbox"/> Getting to scheduled classes and appointments on time |
| <input type="checkbox"/> Walking short distances | <input type="checkbox"/> Taking medications on schedule |
| <input type="checkbox"/> Severe shortness of breath | <input type="checkbox"/> Significant vision or hearing impairment |
| <input type="checkbox"/> Going to the: bathroom bathing dressing (circle all applicable) | <input type="checkbox"/> English language comprehension |
| <input type="checkbox"/> Attending all meals (including breakfast, served 7:30–9:00 a.m.) | <input type="checkbox"/> Bladder or bowel control |
| | <input type="checkbox"/> Significant balance problems/risk for falling |
| | <input type="checkbox"/> Other: _____ |

Please explain any of the areas of possible concern noted above, so that we may be prepared to address your needs:

Within the last 3 years, have you intentionally vomited, used laxatives, or exercised excessively to compensate for overeating?

Yes No If yes, when was the last time?: _____

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: _____

In the past 3 years, have you been diagnosed with or treated for a psychological or emotional problem? Yes No

If yes, please indicate what treatment you received: Outpatient psychotherapy/counseling Psychiatric hospitalization

Other: _____

Mental health provider(s) name(s): _____

Phone number: _____

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 and date below to indicate your permission for a member of our behavioral health staff to talk with the provider(s) listed above.

Signature: _____ Date: _____

Dietary information

Please check any of the following that apply. For any items checked, please indicate the extent to which you adhere to these dietary guidelines.

Vegetarian (avoid some animal products): _____

Vegan (avoid all animal products): _____

Kosher: _____

Food allergies: _____

Other special dietary needs or food restrictions: _____

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.

Reservation information

Admission date (Mondays for new clients): First choice _____ Second choice _____

Program length: 5 days 2 weeks 3 weeks 4 weeks
 More than 4 weeks (please indicate—12 weeks maximum): _____

Are you joining the program with anyone else? Yes No

Name: _____

This person will be: A full-time participant Attending as a support person

For information and policies on support participants, please visit dukedietcenter.org and click on "Family Support" under the Programs menu.

Deposit (new clients only)

New clients must make a \$500 deposit, payable by credit card, check, or money order. If paying by check or money order, please enclose it with this application.

For credit card payment, please indicate: Visa MasterCard AMEX Discover

Name on credit card: _____

Card number: _____ Expiration: _____ Billing ZIP: _____

Insurance information

Do you have Medicare Part B as your primary insurance? Yes No If yes, please include a copy of your Medicare card with this application.

Lodging information

Where will you be staying during the program?

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____

How did you learn about us? (Please indicate specific names if possible)

A program graduate: _____

Physician: _____

Personal reference: _____

Advertisement: _____

Web search engine: _____

Other: _____

Personal Goals Assessment

By filling out the following application carefully and completely, you will help us to get to know you as a person—to understand your goals, as well as physical, genetic, social, and environmental emotional factors that may have an important bearing on your health status and needs. This information will help us to create a personalized health care plan optimally suited to help you be successful.

What do you hope to achieve by attending the Duke Diet & Fitness Center? Check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Lose weight and improve my ability to control my weight over the long term | <input type="checkbox"/> Increase mobility |
| <input type="checkbox"/> Reduce weight and improve physical fitness prior to surgery | <input type="checkbox"/> Gain more energy |
| <input type="checkbox"/> Reduce medications | <input type="checkbox"/> Gain a better understanding of why I eat the way I do, and how to change my eating habits |
| <input type="checkbox"/> Reduce my risk for future health problems | <input type="checkbox"/> Learn how to better manage stress and anxiety |
| <input type="checkbox"/> Improve control of current health problems | <input type="checkbox"/> Improve my mood |
| <input type="checkbox"/> Learn how to exercise safely | <input type="checkbox"/> Improve, and feel more comfortable with, my appearance |
| <input type="checkbox"/> Learn healthy eating habits | <input type="checkbox"/> Someone suggested I lose weight (such as a friend, spouse, or physician) |
| <input type="checkbox"/> Improve my general physical fitness and endurance | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Reduce pain | |

What factors make it challenging for you to lose weight and to become more physically fit? Check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Lack of knowledge of which behaviors I need to change | <input type="checkbox"/> Chronic pain |
| <input type="checkbox"/> Feeling overwhelmed/not sure how to start making changes | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Illness or injury | <input type="checkbox"/> Impaired balance, strength, or other mobility problems |
| <input type="checkbox"/> Lack of willpower | <input type="checkbox"/> Social eating |
| <input type="checkbox"/> Lack of support | <input type="checkbox"/> Business eating |
| <input type="checkbox"/> Loneliness/isolation | <input type="checkbox"/> Death of a loved one |
| <input type="checkbox"/> Excessive worry | <input type="checkbox"/> Work or family commitments |
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Relationship factors |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Habits |
| <input type="checkbox"/> Frequent travel | <input type="checkbox"/> Emotional eating |
| | <input type="checkbox"/> Other: _____ |

What do you consider to be your major health concerns?

What are your personal strengths that can be used to help you create a sustainable lifestyle change program?

Policy on Exercise Tolerance Testing for DFC Clients

Exercise tolerance testing may be helpful to identify clients who are at increased risk for adverse events during exercise training. The following individuals will be required to have an exercise tolerance test (ETT) prior to exercising at the DFC:

- Any new or returning client with known or suspected heart disease based on medical history, symptoms (such as chest pain), physical exam, or EKG findings will be required to present a complete report of a recent ETT (generally, within the past 12 months, but more recently if warranted by current medical status).
- New clients will be required to have an ETT within 12 months prior to admission, if they meet either criterion (a or b) below:
- Return clients will be required to have an ETT within 24 months prior to admission, if they meet either criterion (a or b) below:
 - a) Clients with diabetes
 - b) Men older than age 45 or women older than age 55 with:
 - Regular tobacco use within the past year (daily use of cigarettes, cigars, pipe, or chewing tobacco)
 - Elevated blood pressure
 - Abnormal cholesterol
 - A history within his or her immediate family of early heart disease

Obtaining the test at home and bringing the report will minimize delays in beginning exercise at the DFC. Such testing is usually covered by health insurance. If clients need an ETT and do not bring test results with them, testing can be arranged through the DFC. Please bring your health insurance card, since the cardiology office will file for insurance reimbursement. However, any balance due will be the client's responsibility.

Please note that these are guidelines. The DFC medical staff has final authority in exercise clearance decisions. Please consult our website for complete DFC ETT policies: dukedietercenter.org.

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



501 Douglas Street
Durham, NC 27705
800-235-3853

For details and directions, visit dukedietercenter.org
or e-mail us at DFCINFO@mc.duke.edu.