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Welcome to our practice! We look forward to helping you achieve and maintain your health goals!

Your first appointment will be approximately 45 minutes. The doctor will take your history and advise you of any lab testing he feels is needed in addition to what you may have had done in the past. The nurse will take your body measurements and a picture for your chart. If you have insurance coverage that we are contracted with (Blue Cross/Blue Shield or Arizona Foundation) we will bill your insurance for the medical consultation. If you do not have coverage, the cash fee is **\$175.00**.

The second visit is approximately 1 week later and again will be about 45 minutes. The nurse will do an EKG prior to you seeing the doctor. Dr. Rigden will then go over all labs, EKG and counsel you on the diet plan that best fits your body type and medical needs. A treatment plan will be made specifically for you. You will be given all instructions and options prior to check-out. This visit can also be billed to insurance as a consult. If you are a cash (no insurance) paying patient, the cost for this visit is **\$150.00**.

At some point, you most likely will need to schedule an appointment with our nutritionist. It is usually a ½ to 1 hour appointment, where she will go over any questions you may have and give you assistance with nutritional information. The cost for this visit is **\$40.00 - \$80.00** and may not be reimbursable by insurance companies. If you have Blue Cross/Blue Shield or Arizona foundation, we will bill them, but not all policies cover it and you may be responsible.

Your fourth visit begins the monthly weight management program. These visits are approximately 15 minutes and may consist of a weigh-in, counseling and questions you might need answered. For cash patients (non insurance), you have 4 visits per month, 1 per week. You will alternate between the doctor, the nutritionist and our nurse. The cost for cash patients is **\$160.00** and is payable at the start of the four visits. If you have a contracted insurance we work the program on an every other week basis. By doing it this way, the visits are generally covered by your insurance with a medical diagnosis.

You are expected to keep every appointment, as the visits do not carry over. However, if an emergency does arise, with proper notice, we can help you adjust the times or dates (if our schedule allows). Any nutritional products purchased from our office are an additional cost. For your convenience, we accept MasterCard, Visa, personal check and cash.

Please note if you should miss an appointment without notifying our office 24 hours in advance, there will be a \$35 fee charged to your account.

Please sign and date below, acknowledging you have read and understand the office policy.

Name: _____ Date: _____

Signature: _____

WEIGHT LOSS HISTORY QUESTIONNAIRE

Thank you for filling out this weight loss history form prior to seeing Dr. Rigden.

1. When did you first have a weight problem? _____
2. Regarding your weight (check one)
 - (a) A. I have steadily gained _____
 - (b) B. I have been a "yo-yo" dieter _____
3. Is it difficult or easy for you to lose weight? _____
4. My usual calorie consumption clearly; (check one) my weight issues.
 - (a) Explains _____
 - (b) Does not explain _____
5. My typical daily energy level, rated on a scale of 0-10 is _____
6. My typical daily stress level, rated on a scale of 0-10 is _____
7. Are you a stress eater? (check one)
 - (a) No _____
 - (b) Sometimes _____
 - (c) This is a big issue _____
8. My danger foods are _____
9. My danger times are _____
10. Percentage of meal eaten out _____
11. On the average, how many alcoholic drinks do you consume each week _____
12. My sugar intake is: Low _____ Medium _____ High _____
13. My salt intake is: Low _____ Medium _____ High _____
14. My caffeine intake is: Low _____ Medium _____ High _____
15. On the average, how many soft drinks do you consume each week _____
16. My average daily water intake is _____ ounces
17. Family support for this project is: Negative _____ Neutral _____ Positive _____
18. My personal weight goal is _____ pounds

FUNCTIONAL MEDICINE WEIGHT MANAGEMENT SCREENING QUESTIONNAIRE:

NAME: _____

DATE: _____

INSTRUCTIONS: Please circle each statement(s) that apply to you.

Lifestyle:

1. I eat out ten or more times in a week.
2. I consume 14 or more alcoholic drinks in a week.
3. I seldom eat more than two servings (combined) of fruit and vegetables daily.
4. I consume more than 20 oz of soda daily.
5. I seldom exercise 60 minutes or more weekly.
6. I consume refined sugar/carbohydrates at least several times daily.
7. I frequently eat between meals.
8. Foods such as hamburgers, hot dogs, pizza, fried chicken, fries or chips are consumed almost every day.
9. I have a problem with stress eating or compulsive eating.

Total Circled: _____

Syndrome X:

1. My family history is positive for Diabetes Mellitus.
2. My past medical history is positive for high triglycerides.
3. My past medical history is positive for infertility, unwanted facial hair, or cysts on the ovary.
4. I frequently crave sugar and/or carbohydrates.
5. I experience erratic energy and/or mood swings that can be affected by eating.
6. I gain weight in the upper body or "apple" distribution.
7. I experienced gestational diabetes and/or delivered a baby that weighed more than nine pounds.
8. My past medical history is positive for borderline or confirmed high blood pressure.
9. My past medical history is positive for gout.
10. My ethnic roots are non-European.

Total Circled: _____

Food Allergy/Hypersensitivity:

1. As an infant or small child I had problems with colic, allergies or recurrent respiratory infections.
2. I have a past or current medical history of:
 - A. Asthma.
 - B. Chronic nasal or sinus problems.
 - C. Hives or eczema.
 - D. Irritable Bowel Syndrome.
 - E. Excessive headaches.
 - F. Musculoskeletal aches and pains.
3. I eat a lot of wheat or dairy-based foods.

Total Circled: _____

NAME: _____

DATE: _____

Endocrine:

1. My family history is positive for thyroid problems.
2. I am frequently cold when others are comfortable.
3. My face and body are often puffy and swollen.
4. I am sluggish in the morning and have difficulty getting up.
5. My hair appears less healthy or is falling out.
6. My skin has become dry.
7. My nails are brittle.
8. I have a history of high cholesterol.
9. I am taking a thyroid replacement.
10. I experience craving and weight gain with PMS.
11. My weight gain has been associated with perimenopause or menopause.
12. My weight gain is associated with taking hormone replacement or the birth control pill
13. I have significant issues with decreased libido.
14. My weight gain has coincided with very high stress.
15. I have gained weight distributed in my upper back below the neck level.

Total Circled: _____

Chronic Illness:

1. I started gaining weight after I contracted a chronic illness.
2. I have a chronic illness, e.g., Chronic Fatigue Syndrome, Fibromyalgia, Rheumatoid Arthritis, etc.
3. I frequently feel exhausted.
4. I frequently feel sick all over, like having the flu or mono.
5. I am sensitive to medications.
6. I am sensitive to smoke, chemicals or fumes.
7. I am presently or have in the past taken Prednisone, NSAISDS (Motrin, Advil, ibuprofen), antibiotics, antidepressants or other medications I suspect have contributed to my weight gain.
8. Due to my illness I am quite sedentary.
9. I have had frequent yeast infections (including thrush).

Total Circled: _____

Medical History

1. Prior to the past year, have you had any of the following conditions (check if yes):

- | | |
|---|---|
| <input type="checkbox"/> abnormal bleeding | <input type="checkbox"/> heart failure |
| <input type="checkbox"/> alcohol dependency | <input type="checkbox"/> heart murmurs |
| <input type="checkbox"/> anemia | <input type="checkbox"/> heartburn |
| <input type="checkbox"/> angina | <input type="checkbox"/> hemorrhoids |
| <input type="checkbox"/> anorexia | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> asthma | <input type="checkbox"/> high cholesterol |
| <input type="checkbox"/> blood clot in the lung | <input type="checkbox"/> high triglycerides |
| <input type="checkbox"/> bronchitis | <input type="checkbox"/> irregular heart rate |
| <input type="checkbox"/> bulimia | <input type="checkbox"/> irritable bowel |
| <input type="checkbox"/> cancer or precancerous disease | <input type="checkbox"/> kidney stones |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> measles |
| <input type="checkbox"/> colitis | <input type="checkbox"/> migraines |
| <input type="checkbox"/> depression | <input type="checkbox"/> mononucleosis |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> mumps |
| <input type="checkbox"/> diverticulitis or diverticulosis | <input type="checkbox"/> pancreatic disease |
| <input type="checkbox"/> drug dependency | <input type="checkbox"/> phlebitis |
| <input type="checkbox"/> eczema or dermatitis | <input type="checkbox"/> pneumonia |
| <input type="checkbox"/> emphysema | <input type="checkbox"/> psoriasis |
| <input type="checkbox"/> epilepsy, convulsions, or seizures | <input type="checkbox"/> pulmonary edema |
| <input type="checkbox"/> esophageal or stomach disease | <input type="checkbox"/> rheumatic fever |
| <input type="checkbox"/> gall bladder disease | <input type="checkbox"/> sexually transmitted disease |
| <input type="checkbox"/> gall stones | <input type="checkbox"/> sleep apnea |
| <input type="checkbox"/> German measles | <input type="checkbox"/> stroke |
| <input type="checkbox"/> gout | <input type="checkbox"/> thyroid disease |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> tuberculosis |

2. List all surgeries that you have had, and their approximate dates:

Surgery	Date	Surgery	Date

3. Have you ever been treated with (check if yes):

- | | |
|---|--|
| <input type="checkbox"/> Steroids | <input type="checkbox"/> Digitalis/digoxin |
| <input type="checkbox"/> Adrenaline | <input type="checkbox"/> Nitroglycerin |
| <input type="checkbox"/> Other hormone preparations | <input type="checkbox"/> Other heart medicines |
| <input type="checkbox"/> Anticoagulants or blood thinners | <input type="checkbox"/> Migraine medicines |
| <input type="checkbox"/> Thyroid medicines | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Enzyme supplements | <input type="checkbox"/> Anti-depressant medicines |
| <input type="checkbox"/> Lithium | <input type="checkbox"/> Diuretics or water pills |
| <input type="checkbox"/> High blood pressure medicines | <input type="checkbox"/> Diet pills |
| <input type="checkbox"/> Insulin injections or diabetes pills | <input type="checkbox"/> Seizure/epilepsy medicine |
| <input type="checkbox"/> Frequent or long term antibiotics | <input type="checkbox"/> Birth Control pills |
| <input type="checkbox"/> Other (describe below) | |

FAMILY HISTORY

For each member of your family, follow the grey or white line across the page and check the boxes for:
 1. Their present state of health, and
 2. Any illnesses they have had.

Note: Family refers to blood or natural relatives.)	Good Health	Poor Health	Deceased	Write in age and cause of death. Include accidents and suicides.	Alcoholism	Allergies or Asthma	Alzheimer's or Dementia	Anemia	Blood Clotting Problems	Diabetes	Cancer or Tumor	Epilepsy	Genetic Disease	Heart Trouble	High Blood Pressure	Kidney or Bladder Dis.	Nervous Breakdown	Rheumatism or Arthritis	Stomach or Duodenal Ulcer	
Father:																				
Mother:																				
Brothers/Sisters:																				
Child:																				
Child:																				
Child:																				
Child:																				
Paternal relatives (in each box, write in how many affected with condition):																				
Maternal relatives (in each box, write in how many affected with condition):																				

- Any other family history we should know about? Yes ___ No ___
 If so, please comment:
