OrthoHealth
A Metabolic Approach to an Active Lifestyle
by Illinois Bone & Joint Institute

Welcome!

You have been invited to participate in Illinois Bone & Joint Institute OrthoHealth Program

OrthoHealth is an exclusive IBJI program that offers a collaborative approach to improve your health and wellness. Our providers include Obesity Medicine Physicians, Physical Therapists, Health Coaches and Registered dietitians. Our program focuses on the following 5 areas and will be tailored to your needs, incorporating all aspects or just focusing on the areas you need:

- **Optimizing Metabolic Health:** Our physicians will focus on unlocking and addressing your personal medical parameters and finding an individualized plan to help you achieve metabolic health. This will result in an increase in energy, strength and overall metabolism resulting in weight loss.
- **Reducing Stress:** Is stress taking a toll on your health? Do you feel tired or drained some days? The OrthoHealth team will explore your lifestyle and assist you in creating habits to be the best version of yourself. Reducing your stress will lower overall cortisol levels and assist with optimizing your metabolic health.
- **Physical Therapy to achieve Pain-free Movement:** Our team of Physical Therapists can assess your current lifestyle and take a whole body approach to evaluate and design an individualized treatment plan in conjunction with your IBJI physicians with the goal of achieving pain free movement. Your pain free movement will be a key factor in achieving your metabolic health.
- **Nutrition:** Learning proper nutrition to fuel your body is the key to performance and recovery. We can educate you on your daily intake of protein, vitamins, minerals and proper hydration to optimize your energy and fitness.
- **Sleep:** Sleep is a critical component to health. With our sleep partners we can evaluate current sleep patterns and sleep hygiene and if needed set up interventions to improve quality or quantity sleep which will reduce overall stress hormones and boost energy levels and metabolism.
- **HPI:** Our Health Performance Institute will come together with your medical providers to educate you in the importance of exercising with efficient movement and design a program to complement the current goals set by your OrthoHealth providers. They offer In person and Virtual individual and group sessions.

How to Enroll: Scheduling is simple, we offer in person and virtual visits, just reach out to our intake coordinator at 847-324-3020 to get started.

Please visit our website: **www.ibji.com/services/orthohealth/orthohealth-program/**

IBJI OrthoHealth– Adult Program Intake

Please take a few minutes to answer the following. These items will be discussed more in depth with your OrthoHealth provider.

Patient Name _____ **Date of Birth** _____ **MRN** *(office use only)* _____

Who referred you to the OrthoHealth program? _____

Program Information

What do you hope to learn, achieve or gain from the OrthoHealth program?

_____

_____

Weight History

Current Height: _____ft_____in. Current Weight: _____ Weight at Age 20:_____

Lowest Adult Weight:_____Age/Year:_____Highest Adult Weight:_____Age/Year:_____

Weight: 6 months ago_____1 year ago_____5 years ago_____10 years ago_____

What is the main reason you are interested in the OrthoHealth program?_____

_____

When did you start gaining extra weight? Please provide possible reasons for weight gain if known. Is there a particular inciting event that you can identify?

_____

_____

_____

Please list previous weight loss/nutrition programs or diets you have tried:

Program	Dates	Results/Comments

Which of the above worked best and why?_____

_____

What do you think is the biggest obstacle that has prevented or might prevent you from losing weight?

_____

_____

Have you ever used over the counter or prescription medications for weight loss? ☐ Yes ☐ No

If yes, please list which medication, when and what were your results.

_____

_____

Patient Name:_____

Nutritional Habits- Please include your typical daily diet

Meal	Time	Foods	Drinks	Notes
Breakfast				
Morning snacks				
Lunch				
Afternoon snacks				
Dinner				
Evening snacks				

How many breakfasts do you skip per week?_____How many lunches do you skip per week? _____

How many dinners do you skip per week? _____ Do you often graze? ☐ Yes ☐ No

Do you feel satisfied/full after meals? ☐ Yes ☐ No

Do you frequently eat in the middle of the night? ☐ Yes ☐ No

Do you consider yourself a stress eater? ☐ Yes ☐ No

What time of day do you feel most hungry? _____

How many meals do you eat out or take out per week? (include breakfast, lunch and dinner)_____

Who does the grocery shopping? _____ Who does the cooking? _____

Do **you** enjoy cooking? ☐ Yes ☐ No

Patient Name:_____

What are your favorite foods?

_____

_____

What are some of the foods you will not eat?

_____

_____

What types of foods do you crave?

_____

_____

Stress

How would you describe yourself? (Select One Option)

☐ I am calm and easy going ☐ I am sometimes calm but frequently impatient
☐ I am hard driving and can never relax
☐ I am seldom calm and have overwhelming drive for ambition

Please select your stress level:
(0= No Stress, 5= Moderate Stress, 10= Extreme Stress)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Please describe major sources of stress in your life and how they affect you:

_____

_____

_____

What helps you relieve your stress?

_____

_____

_____

Sleep Habits

What time do you get into bed? _____ What time do you turn off the lights? _____

What do you do in bed before going to sleep? _____

_____

Is your cell phone in the room with you? ☐ Yes ☐ No Do you use your phone as an alarm clock ☐ Yes ☐ No

What time do you usually wake up?_____ Do you wake up during the night? _____

Do you snore? ☐ Yes ☐ No ☐ I don't know

Do any of these describe you?

I wake up in the morning still tired ☐ Yes ☐ No

I have to take naps during the day ☐ Yes ☐ No

Patient Name:_____

I have to sleep with >1 pillow	☐ Yes ☐ No
Have you ever had a sleep study?	☐ Yes ☐ No
I wake up feeling well rested	☐ Yes ☐ No
I wake up with a dry mouth and sore throat	☐ Yes ☐ No

Does your work involve constantly changing shifts disrupting your sleep schedule? ☐ Yes ☐ No

On a scale of 0-10, how would you rate the quality of your sleep?
(0-poor sleep, 5-moderate or ok sleep, 10 best sleep)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What concerns you most about your sleep, if anything?

_____

_____

_____

Activity / Exercise

How would you rate your current level of activity (i.e. cleaning, gardening, walking, dancing, yoga, cycling) in your daily life on a scale of 0-10? (0=low I do the essentials of daily living, 5=moderate I can do some activity but need to take rest breaks, 10= I am active and moving all the time with no problem.)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What activity or exercises do you enjoy?

_____

_____

_____

What physical activity or exercise have you done in the past 30 days?
(PT, shoveling, gardening walking, swimming, strength training, Pilates, Beach Body)

Activity	How Many Times A Week	For How Long
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

To the best of my knowledge, the above information is accurate and complete.

Patient Signature_____Date

OrthoHealth – Personal & Family Medical History

Patient Name _____ **Date of Birth** _____ **MRN** *(office use only)* _____

Current Prescription Medication & Over the Counter Herbs/Supplements

Medication/Herbs/Supplement	Dosing	Purpose	Year Started

Allergies

Are you allergic to any medication?	☐ Yes ☐ No
Allergy:	Reaction:
Allergy:	Reaction:
Please list additional allergies to food, supplements, environmental, other:	

Prior Surgeries

Date:	Surgery**:**
Date**:**	Surgery**:**
Date**:**	Surgery**:**

Prior Hospitalizations

Date:	Reason:
Date**:**	Reason:
Date**:**	Reason:

Personal Medical History (Please select all that apply.)

Current Symptoms (Please check any of the following you are currently experiencing)

Endocrine:
☐ Fatigue ☐ Always Cold ☐ Always Hot
☐ Excessive thirst ☐ Irregular Menses/No Menses ☐ Postmenopausal
☐ Acne ☐ Excessive facial hair ☐ Erectile dysfunction
☐ Low libido

Cardiovascular:
☐ Palpitations ☐ Irregular Heartbeat ☐ Chest pain
☐ Leg swelling ☐ Have to sleep with multiple pillow

Patient Name:_____

Pulmonary/ Breathing:	☐ Coughing	☐ Wheezing	☐ Snoring
	☐ Shortness of breath while walking, climbing stairs or exercising		
Gastrointestinal:	☐ Reflux/heartburn	☐ Abdominal pain	☐ Constipation
	☐ Nausea	☐ Diarrhea	
Neurological/ Psychiatric:	☐ Headaches	☐ Numbness/Tingling	☐ Tremors
	☐ Depression	☐ Anxiety	☐ ADHD
	☐ Insomnia		

Other:_____

Self History – (Please check all that apply to you)

Previous Abnormal EKG	☐	Bulimia	☐
Osteopenia/Osteoporosis	☐	Binge Eating Disorder	☐
ADHD	☐	Irritable Bowel Syndrome	☐
Anorexia	☐	Crohn's/Ulcerative Colitis	☐
Gallbladder disease	☐		

Personal & Family Medical History (Please check all that apply to you & family)

	Self	Mother	Father	Grandparent	Sibling	Aunt/Uncle
High Blood Pressure	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Heart Attack or Stent	☐	☐	☐	☐	☐	☐
Heart surgery (Bypass)	☐	☐	☐	☐	☐	☐
Sudden Death before 50	☐	☐	☐	☐	☐	☐
Stroke/TIA	☐	☐	☐	☐	☐	☐
Pulmonary Embolism or Other Clotting Disorder	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐	☐	☐
Lupus	☐	☐	☐	☐	☐	☐
Sjogren's Syndrome	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Osteopenia/Osteoporosis	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Asthma / Emphysema or COPD	☐	☐	☐	☐	☐	☐
Gout	☐	☐	☐	☐	☐	☐
Cancer What Type:_____	☐	☐	☐	☐	☐	☐

Date Of Last Physical Exam with PCP: _____ Date of Last Completed Labs:_____

Date of Last EKG:_____ Date of Last Stress Test:_____

Have you previously been diagnosed with cancer? ☐ Yes ☐ No

Patient Name:_____

Have you previously been diagnosed with an Autoimmune Disease? ☐ Yes ☐ No

Have you previously been diagnosed with Sleep Apnea? ☐ Yes ☐ No

If yes, do you use a CPAP machine? ☐ Yes ☐ No When was your last sleep study? _____

If no, have you ever had a sleep study? ☐ Yes ☐ No If yes, when? _____

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Life Partner ☐ Widowed

Who lives at home with you, including pets? _____

Employment/Work Status: ☐ Full time ☐ Part time ☐ Self Employed ☐ Homemaker ☐ Retired ☐ Student

Occupation:_____

Activity During The Day ☐ Sit At Desk ☐ Active Most of Day ☐ Somewhere In Between

Smoking History

☐ I have never smoked cigarettes, cigars or pipe ☐ I previously smoked but quit_____years ago

☐ I currently smoke the following number of packs per day_packs/day

Alcohol Use

☐ I do not drink any alcohol ☐I previously drank, but quit_____(year) History of Alcoholism? ☐ Yes ☐ No

☐ I currently drink the following number of alcoholic beverages per week:_____drinks/week

Drugs/Illicit Substances

Have you ever given yourself street drugs with a needle? ☐ Yes ☐ No History of any drug addiction? ☐ Yes ☐ No

Are you currently using any street/illicit drugs? ☐ Yes ☐ No

Do you use Recreational Marijuana ☐ Yes ☐ No If yes, how often? _____

Do you carry a Medical Marijuana Card ☐ Yes ☐ No If yes, for what medical reason? _____

Sexual/Reproductive History

Are you trying to become pregnant? ☐ Yes ☐ No If you are using a contraceptive, what method?_____

Do you have a history of infertility? ☐ Yes ☐ No When was your last menstrual cycle?_____

Are your menstrual cycles regular? ☐ Yes ☐ No

Have you had Gestational Diabetes with any pregnancy? ☐ Yes ☐ No

Have you been diagnosed with Polycystic Ovarian Syndrome? ☐ Yes ☐ No

To the best of my knowledge, the above information is accurate and complete.

Patient Signature_____Date___/____/ ___