



The Mandolean[®] program Application form

Fill in the form as carefully as possible and send to: **Mandolean AB, Box 4006, 141 04 HUDDINGE, Sweden**

We will contact you after your application has been assessed.

Please note: Submission of the Application Form doesn't automatically lead to admission to the Mandolean[®] program. If you need to get in touch with us quickly, please contact us at: info@mandolean.se or call: +46 (0)8 122 096 00.

Name:	Today's date:
Age: <input type="checkbox"/> Female <input type="checkbox"/> Male	Social Security No:

Phone	Home:	Work:	Cell Phone:
Address	Street:	Zip Code:	City:
E-mail:			

Insurance Company:	
Name of your Physician:	Phone:

If you are less than 18 years old:

Name of mother:	Phone:
Name of father:	Phone:

1. How tall are you? _____ cm.

2. How much do you weigh? _____ kg. BMI: _____ kg/m² *We will calculate this number*

3. Has your body weight changed during the past year?

- no, my weight has remained constant*
- yes, my weight has increased*
- yes, my weight has decreased*
- yes, my weight has increased and decreased*

4. If yes, how much has your weight increased or decreased during the last year?

- 5 kg or less* *6-10 kg.* *11 kg or more*

5. Do you have medical problems?

- no*
 yes: _____

6. If you are female; do you menstruate?

- yes, regularly*
 yes, but irregularly
 no, my periods have ceased
 no, I never had a period

7. Do you regularly take any medicine(s)?

- no*
 yes: _____

8. What is your resting pulse: _____ beats/minute

(sit/or lie down for ten minutes, take your pulse using finger pressure just above your thumb and look at your watch to measure time at the same time)

9. How many minutes a day are you physically active (running, walking, workout)?

_____ minutes

10. Did you have a serious "life event" (for example divorce, death) last year?

- no*
 yes: _____

11. What is your desired weight? _____ kg.

12. How long have you had problems with food?

13. What does your pattern of overeating look like?

- overeating every day*
 overeating mainly on weekends
 overeating in periods, in between I eat normally
 overeating in periods, in between I fast/diet

14. Are you afraid of being unable to stop eating when you have started?

- yes* *no*

15. Has it happened that you have vomited after you have eaten?

- never*
 yes, on occasion
 yes, regularly

16. What does your usual binge-eating pattern (rapid, uncontrolled consumption of large quantities of food) look like?

- I do not binge-eat*
 I binge-eat daily
 I binge-eat in periods, in between I fast/diet/starve
 I binge-eat in periods, in between I eat regularly

17. Did you visit a physician or a hospital because of your overweight/obesity?

- no*
 yes: _____

18. Are you waiting for treatment at a weight loss program?

- yes, I have applied to:* _____
 no, but I plan to apply to: _____

When: _____

- no, I have not applied for treatment.*

19. Is there anything else about your situation which we should be aware of?