Medical Weight Loss Program Intake Form

Patient Name: (Last) (First) (MI)

_____

Patient Address: _____ City: _____State: _____Zip:_____

Phone Number: _____Email: _____

Birthdate: _____Age: _____ Sex: M F

Occupation: _____

In Case of Emergency:

Name: _____ Relationship: _____

Phone: _____

How did you hear about us? _____

Are you under the care of a qualified healthcare professional? Please list whom. *

_____

As detailed in the Consent portion, it is highly recommended that you are under the care of a qualified healthcare professional, who has verified that it is safe for you to exercise and be on a weight loss program and is monitoring medications and any health concerns that you list here (besides your weight issues- that's what we're covering). If you are on medications (particularly for high blood pressure, heart issues, or diabetes), you will need these to be monitored during and after the program as your need for them may change. *

I acknowledge the above statement above. Sign: _____

Medical History

Please list any medical conditions a medical provider has diagnosed you with in the past (such as high blood pressure, diabetes, arthritis,
etc.…): *_____
_____

What medications, supplements and over the counter items do you take regularly or are currently prescribed: *

_____
_____

Any past surgeries and
hospitalizations? *_____
_____

Please describe your family history in terms of heart disease, diabetes, obesity, high cholesterol, high blood pressure, and cancer:_____
_____

Personal History

What are your main interests and hobbies? _____

What is your line of work or study?_____

Do you exercise regularly? Please detail._____

What kind of other movement or activities do you enjoy?_____

You have problems falling or staying asleep?_____

How many hours do you sleep?_____

Do you wake up refreshed?_____

How is your energy?_____

Does your energy level affect your daily activities?_____

How would describe your mood, generally:_____

Does your mood affect your life or daily activities?_____

How would you describe your stress level?_____

What are your sources of stress?_____

How do you manage stress?_____

Do you have people close to you who support you?_____

Diet and lifestyle

Do you regularly drink alcoholic beverages? If yes, how many per week?

Do you smoke tobacco? Do you use recreational drugs?

How is your appetite?

Snack Habits:

What: _____

How much: _____

When: _____

Typical Breakfast:

What:_____

How much:_____

When:_____

Typical Lunch:

What:_____

How much:_____

When:_____

Typical Dinner:

What:_____

How much:_____

When:_____

How often do you eat out? _____

What restaurants do you frequent?_____

How often do you eat "fast foods"?_____

Food allergies?_____

Food dislikes?_____

Food cravings?_____

Do you eat because of emotions (explain)?_____

Do you drink coffee or tea? Yes No If Yes, how much daily?_____

Do you drink pop / soft drinks? If yes, how much?_____

Do you use sugar substitutes?_____

What are your worst food habits?_____

How much fluids do you normally drink? Please approximate in ounces. _____

Please list all types of beverages you regularly drink. _____

_____

Please list any food allergies, intolerances, or foods you avoid and the reason.

_____

_____

What past struggles and difficulties have you experienced in terms of food and dieting?

_____

_____

What diet and exercise programs, protocols, plans or approaches have you tried in the past?

_____

_____

_____

What types of diet and exercise approaches have worked for you in the past?

_____

_____

_____

And what hasn't worked for you at all?

_____

_____

_____

When did you first become overweight?

_____

How did your weight gain start? Describe any circumstances:

_____

_____

_____

What do you think is the cause of your weight problem?

_____

What was your highest weight? (Excluding pregnancy)_____

What was your lowest weight?_____

Have you ever stayed the same weight for 10 years or more?_____

How MOTIVATED are you to lose weight?

_____

_____

Is there anything else you would like to tell us?_____

_____

Please circle the factors you feel have contributed to your current weight (circle all that apply)

Slow metabolism Family history of obesity Comfort food dependency Lack of exercise Binge eating Late night snacking History of trauma History of grief and loss Medications Eating disorder

Please answer the following questions to the best of your knowledge:

Health History *

	No, never	Yes, currently	Not currently, but within the last year	Not currently and longer than 1 year ago
Fatigue				
Unexplained weight loss or gain				
Change in appetite				
Depressive symptoms				
Anxiety				
Mood swings				
Nervousness				
Addictive dependency				
Disordered Eating Pattern/Tendency				
Tension				
Lack of mental focus				
Thyroid problems				
Diabetes				
Blood sugar irregularities				
Excessive thirst or hunger				
Sugar cravings				

Abnormal hair growth				
Excessive perspiration				
Feeling excessively hot or cold				
Headache				
Lightheadedness				
Joint pain or stiffness				
Muscle weakness or soreness				
High blood pressure				
Heart murmur/palpitations				
Cold or pale extremities				
Asthma				
Short of breath				
Heartburn				
Abdominal discomfort after eating				
Nausea				
Abdominal bloating				
Belching/gas				
Constipation				
Diarrhea				
Daily bowel movements				