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…): *

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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.

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

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____

____

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

____

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____

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

____

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____

And what hasn't worked for you at all?

____

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____

____

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?

____

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

Factor	
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	
Medication related weight gain	
Significant restrictive eating behaviors like anorexia	

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				
Lightheadednes				
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				