Weight Loss New Patient Intake Form

Welcome To Our Office! Please Fill Out The Following Information Thoroughly. Please Feel Free To Ask Any Questions If You Need Assistance. We Look Forward To Serving You!

Name: _____ Date: _____

Address: _____

City / State / Zip: _____

Primary Phone#: _____ Secondary Phone#: _____

Email Address: _____

Date of Birth: _____
How Were You Referred To This Office: _____

Are you in good health at the present time to the best of your knowledge? Yes No

Are you under a doctor's medical supervision at this time? Yes No
If Yes, for what?
_____

Are you taking any medications at the present time? Yes No
If Yes, what medications? _____
_____

Do you take vitamin supplements? Yes No
If Yes, what do you take? _____
_____

History of high blood pressure? Yes No

History of diabetes? Yes No

History of frequent headaches or migraines? Yes No
If Yes, how often? _____ Medication? _____
History of constipation? Yes No

Serious injuries? Yes No
Details: _____

Surgeries? Yes No
Details: _____

Do you have a <u>family</u> history of:

- Diabetes? If Yes, Who? _____
- Heart Disease? If Yes, Who? _____
- Cancer? If Yes, Who? _____
- Stroke? If Yes, Who? _____
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<u>Nutritional Evaluation:</u>

Present Weight: _____ Height: _____ Desired Weight:_____

When would you like to be at your desired weight? _____

Why do you want to lose weight? (Health Benefit? Appearance?) Please explain thoroughly:

_____
_____

When did you begin gaining weight? _____
Reason why? _____

What has been your maximum weight (non-pregnant) and when? _____

Have you tried other weight loss programs? Yes No
If yes, which ones? _____

Were you successful with it / were you able to keep the weight off? Yes No
Please explain: _____

Is your spouse, fiancé or partner overweight? Yes No
By how much is he/she overweight?
_____

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? Yes No If Yes, how much daily? _____
Do you use sugar substitutes? Yes No
If Yes, what? _____
What are your worst food habits?
_____
_____
Snack habits:
What: _____
How Much: _____
When: _____
When there is increased stress in your life, do you tend to eat more? Yes No
Explain: _____
Typical Breakfast:
What: _____
When: _____
Typical Lunch:
What: _____
When: _____
Typical Dinner:
What: _____
When: _____
Describe your energy level?
_____
Activity Level: (check one)
_____ Inactive
_____ Light Activity
_____ Moderate Activity
_____ Heavy Activity
_____Vigorous Activity

On a scale of 1 to 10 with 10 being **MOST** committed, how committed are you to taking action and making a change in your life today? 1 2 3 4 5 6 7 8 9 10

_____ _____
Patient Signature Date

_____
Patient Name Printed