Name: _____ Today's Date:_____

Intake: weight-loss

What's your current height and weight?

Height:
Weight:
BMI:

Are you currently pregnant or breastfeeding?

- ☐ No
- ☐ Yes

Which of the following do you have trouble with?

- ☐ Appetite
- ☐ Cravings
- ☐ Not enough exercise
- ☐ Slow metabolism
- ☐ Stress eating
- ☐ Late night eating
- ☐ None of the above

Which have you tried in the past?

- ☐ Dieting
- ☐ Exercise plans
- ☐ Coaching
- ☐ Medications
- ☐ None of the above

Which of the following have you tried in the past?

- ☐ Keto or low carb
- ☐ Weight Watchers
- ☐ Plant-based
- ☐ Macro or calorie counting
- ☐ Noom
- ☐ Calibrate
- ☐ Alpha
- ☐ Push Health
- ☐ None of the above

Have you ever been diagnosed with any of the following?

- ☐ Type 1 diabetes
- ☐ Pancreatitis
- ☐ Gastroparesis
- ☐ Seizures
- ☐ Glaucoma
- ☐ None of the above

Have you ever been diagnosed with any of the following?

- ☐ Type 2 diabetes
- ☐ Sleep apnea
- ☐ High cholesterol
- ☐ High triglycerides
- ☐ Prediabetes
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Osteoarthritis
- ☐ Polycystic ovarian syndrome (PCOS)
- ☐ Non-alcoholic fatty liver disease
- ☐ None of the above

Do you, your siblings, or your parents have a history of the following conditions?

- ☐ Medullary thyroid cancer
- ☐ Multiple endocrine neoplasia type 2
- ☐ None of the above

Are you allergic to any medications?

- ☐ No
- ☐ Yes: _____

Are you currently taking any of the medications below?

- ☐ Insulin
- ☐ Sulfonylureas
- ☐ Opioid pain medication
- ☐ None of the above

Do you currently have any other medical conditions besides those that you have already shared with us?

Have you previously had any of the following weight loss surgeries? If yes, please provide date of surgery.

- ☐ Sleeve gastrectomy
- ☐ Laparoscopic adjustable gastric band (Lap-band)
- ☐ Roux-en-Y gastric bypass
- ☐ Gastric balloon
- ☐ Other procedure
- ☐ No, I haven't had any of the above surgeries

List any other surgical history:

_____

_____

Do you have a history of kidney disease or abnormal kidney function?

- ☐ No
- ☐ Yes

Which of the following medications have you used?

- ☐ Phentermine
- ☐ Qsymia
- ☐ Contrave
- ☐ Topiramate
- ☐ Zonisamide
- ☐ Bupropion
- ☐ Naltrexone
- ☐ Metformin
- ☐ None of the above

If you indicated you have taken any of the listed medications, answer the following:

How long did you take above medication?

_____

Was it effective? _____

Did you experience any side effects?

_____

When did you last take it?_____

Which GLP-1 medications have you taken?

- ☐ Compound Semaglutide
- ☐ Wegovy (Semaglutide)
- ☐ Ozempic (Semaglutide)
- ☐ .Mounjaro (Tirzepatide)
- ☐ Saxenda (Liraglutide)
- ☐ Victoza (Liraglutide)
- ☐ Compound Tirzepatide
- ☐ None of the above

Dose:_____

Date of last injection: _____

Do you currently take any medications or supplements? If yes, pls list:

_____

_____

_____

_____

Have you felt depressed in the past month?

- ☐ No
- ☐ Yes

Have you tried a weight management program for at least 6 months within the past year? (e.g. Noom, Weight Watchers)

- ☐ Yes
- ☐ No

What race do you identify with?

- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or other Pacific Islander

Please describe your weight loss journey.

What have you previously tried for weight loss? What has or hasn't worked?