Incredible Family Health & Wellness
Weight Management Plan/Evaluation

Program Start Date:	
How would you describe your overall health?	
Current Weight (lbs):	BMI:
Ideal Weight (lbs):	
What is your target date for your ideal weight goal?	
Do you have a history of medullary thyroid cancer?	
Female: Birth Control method?	
Has your weight interfered with your ability to participate in daily activities?	
Current Exercise Regimen/minutes a day/how often?	
How many hours a day do you sleep?	
Have you tried to lose weight before and what did you use/do?	
Are you currently taking any medications to treat obesity? Prescription or OTC?	
Have you recently been referred to another healthcare professional for your weight/obesity?	
Have you recently had any labs related to your weight/obesity? Types of Labs?	
Do you feel your weight/obesity is affecting you emotionally?	
How many calories do you consume daily?	

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Weight Management Follow Up/Evaluation

Follow up Date:	
Current Weight:	BMI:
Current Weight Management Medications?	
Are you taking any injectable supplements?	
Are you using oral supplements?	
Any new medications (prescription or OTC)?	
Females: Last menstrual cycle?	
Are you currently pregnant?	
Has your sleep pattern changed? Have you noticed any insomnia?	
Are you having any symptoms of GERD?	
Any nausea and or vomiting?	
Any symptoms of constipation?	
When was your last BM?	
Are you using any laxatives?	
Any unusual behaviors or changes in behaviors or suicidal thoughts? Any seizure activity?	
Have you noticed any change in your heart rate or blood pressure?	
Have you noticed any change in your weight?	
Have you noticed any change in your energy level/activity?	
Do you feel your health has improved since your last visit?	
Are you satisfied with your weight loss to date?	