Intake Form and Health Screening Questionnaire

Name_____ Today's date (MM/DD/YYYY): _____

Date of Birth (MM/DD/YYYY): _____ Age: _____

Preferred phone: _____(home/cell) Alternate phone: _____(home/cell)

Email: _____

Emergency Contact

Name: _____ Relationship: _____

Preferred phone: _____(home/cell) Alternate phone: _____(home/cell)

Physician Info

Primary physician: _____ (_____) _____

Other physicians involved in your treatment/care: (use reverse side if necessary)

Name	Specialty	Phone number
_____	_____	(_____) _____
_____	_____	(_____) _____
_____	_____	(_____) _____

How did you learn about the Healthy Ways program? _____

Medical History – General

Have you ever had any of these health problems?

Pulmonary (lung) problems	Yes	No
Heart problems or surgery	Yes	No
Diabetes	Yes	No
Altered heart rate	Yes	No
Dizziness or fainting (unrelated to cancer treatment)	Yes	No
Chest, neck or arm pain	Yes	No
Pain or cramping in legs while walking	Yes	No
Cancer	Yes	No
Elevated blood pressure	Yes	No
Low blood pressure	Yes	No
High cholesterol	Yes	No
Smoker or previous smoker	Yes	No
Arthritis	Yes	No

If the answer is yes to any of the above, please describe briefly:

_____

_____

Other major illnesses (include surgeries/accidents/chronic pain)

_____

_____

_____

_

Medications/Lifestyle/Other:

List current medications (including vitamins and over-the-counter)

_____
_____
_____

Describe your health at the present time: Excellent Good Fair Poor

List types of exercise you participate in regularly and describe the frequency of your practice

_____
_____
_____

Do you have any physical limitations that restrict your daily living activities or ability to exercise?
No Yes If yes, please explain:

_____
_____

Are you currently working? Yes No

What is your level of activity at work? Completely sedentary Moderately active Very active

Describe your past experience with detoxing:

_____
_____
_____

Do you have any concerns about starting this detox program?

_____
_____
_____

Are you currently following any specific diet plan or weight loss program? If so, please list all that apply.

_____
_____
_____

What, if any, weight management or weight loss program/s have you tried in the past?

_____
_____
_____

Who in your household is responsible for food shopping and food preparation?

_____
_____
_____

How many meals/snacks per week are eaten outside the home?

_____
_____
_____

Do you have any concerns about changing your food choices and eating behaviors?

_____
_____
_____

Are you willing to commit to precisely tracking your exercise and food intake through the use of a journal or log for the duration of the program?

_____
_____
_____

How will you determine your personal success/satisfaction with this program?

_____
_____
_____

What expectations do you have from this program?

_____
_____
_____

How will you determine personal success/satisfaction with this program?

_____
_____
_____

What is your preferred intake overview call time? Please number them from 1 to 2 with 1 being your first choice. If this call time is impossible for you to make, please leave it blank and we will schedule another time that best fits your schedule.

____ Tuesday AND Thursday 9:00– 10:00 a.m.
____ Tuesday AND Thursday 6:00– 7:00 p.m.