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 with name and phone number. *

_____

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 understanding to the above statement. 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…): *

_____
_____
_____
_____
_____

What medications, supplements and over the counter items do you take regularly or are currently prescribed: *

_____
_____
_____
_____
_____

Any past surgeries and/or major 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?

_____
_____

Do you have any major sleep problems such as sleep apnea, narcolepsy, etc?

_____

How do you manage stress?

_____
_____

Do you have people close to you who support you?

_____
_____

Diet and lifestyle

Do you regularly drink alcoholic beverages? Y___ N___ If yes, how many per week?___

Do you smoke tobacco? Y___ N___ If yes amount per day/how long?_____

Do you Vape? Y___ N___ If yes how much and for how long?_____

Do you use recreational drugs? (No judgement or legal intentions. Strictly medical) Y___ N___
If yes, what?_____

How is your appetite? Always hungry_____ Hungry at meal times_____

How many meals a day do you eat?_____

How many meals in a week do you eat out?_____

Snack Habits:

What:

_____
_____

How much:

_____
_____

When:

_____
_____

Typical Breakfast:

What do you eat for breakfast and when do you usually eat breakfast:

_____
_____

How much? (one serving, two servings, etc)

_____

Typical Lunch:

What do you eat for lunch and when do you usually eat lunch:

_____

How much? (one serving, two servings, etc)

_____

Typical Dinner:

What:

_____
_____

How much:

_____

Food allergies/intolerances?

_____

Food dislikes?

_____

Food cravings?

_____

Do you eat because of emotions (explain)?

_____

Do you drink coffee, tea or caffeinated sodas? Yes___ No___ If Yes, how many daily?_____

Do you use sugar substitutes? What kind? (Aspartame, Stevia, Sucralose, etc.)

_____

What are your worst food habits?

_____
_____

How much fluids/H2O do you drink daily? Please approximate in ounces. Can be fizzy water or plain water.

_____

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

_____
_____
_____

What diet and exercise programs, protocols, plans or approaches have you tried in the past? Last time you were in a "diet"
program?_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____

And what hasn't worked for you at all?

_____
_____
_____
_____

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?

_____
_____
_____
_____

What do you feel is needed for you to be successful? (Habit changes, understanding food, motivation, etc.)

_____
_____

Is there anything else you would like to tell us?

_____
_____
_____

_____

_____

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

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				