Wellness & Weight Loss - OPTIONAL

Name: _____ Date of Birth: _____ Height: _____

Your overall health is of utmost importance to us, and your weight can significantly affect your treatment plan in our clinic. For this reason, we are including at no additional cost, a health consult to help you create an action plan for any of the issues listed below. Our Certified Health Coach will give you a call to schedule your consult.

Please select if you have had or currently have any of the following conditions:

_____ Migraines
_____ Diabetes
_____ High Blood Pressure
_____ Thyroid Disorder
_____ Food Allergies
_____ Heart Problem
_____ High Cholesterol
_____ Stress
_____ Indigestion
_____ Constipation
_____ Eating Disorder
_____ Depression
_____ GERD
_____ Cancer
_____ Sleep Apnea

Do you have any other medical conditions not listed above? _____

HEALTH / Weight Goals and History

Present weight? _____ **Desired weight?** _____ **Goal for desired weight? (month/year)** _____
Highest weight in past 3 years _____ Lowest weight in the past 3 years? _____

What weight loss programs have you tried and for how long?

_____ _____

_____ _____

Have you had long-term success (kept weight off longer than a year)? _____

What type of work do you do? _____
How often do you exercise? ____ Rarely ____ 1-2 days/week _____ 3-5 days/week ____ 6-7 days/week

How long is your exercise per session? _____ None _____ <30 min _____ 30-60 min _____1 hr ___ >1hr

Types of Exercise? (select all that apply) _____ Walk ____Jog/Run _____Weight Train _____Bike ____ Other

How would you describe your general stress level? _____ High Stress _____ Moderate _____ Low Stress

How many hours of sleep do you get per night? _____ <4 hrs _____ 4-5 hrs _____ 6-8 hrs _____ >8 hrs

How do you feel mostly throughout the day? _____ Tired & Fatigued _____ Energetic & Alert

How many times do you eat a day? _____ Do you often have cravings for sugary or salty foods? _____

Do you struggle with eating healthy and regularly? _____

Select the statement that best describes you (check one)

____ I eat a very healthy balanced diet, consisting mostly of fresh fruit and vegetables, lean meats, and plenty of water. I rarely eat "junk food" or fast food.

____ I eat a moderately healthy diet, but on occasion eat unhealthy foods. I eat fast food/restaurant food 1-3 times a week. I drink sodas sometimes.

____ I eat a mostly poor and unhealthy diet. I eat junk food almost everyday and fast food more than 4 times a week. I drink sodas often instead of water.

Signature of Patient, Parent or Guardian _____ **Date** _____

Contact number _____ **Best time to call** _____