ONE Health FIT Program Intake Questionnaire

Welcome to **ONE Health FIT**! Help us help YOU by completing these forms.

First Name _____Middle Initial: _____ Last Name: _____

Date of Birth: _____ Social Security Number: _____

Marital Status (please circle one): Single Married Other _____ Sex: ☐ Male ☐ Female Preferred Language: _____

Street Address: _____ Phone Number: _____

City, State, Zip Code: _____County: _____

Email Address: _____ @ _____

Race: ☐ White ☐ African American ☐ Asian ☐ Other_____ Ethnicity (please check one): ☐ Hispanic ☐ Non-Hispanic

Veteran (please check one): ☐ YES ☐ NO Check if one of these apply: ☐ Homeless ☐ Seasonal Worker ☐ Migrant

INSURANCE INFORMATION

Primary Insurance Carrier ID #:_____Group #: _____

Insurance Company :_____ Insurance Company Phone # _____

Insured's Name:_____ Relationship: _____ Insured's Date of Birth _____

Secondary Insurance Carrier ID #:_____Group #: _____

Insurance Company :_____ Insurance Company Phone #_____

Insured's Name: _____ Relationship: _____ Insured's Date of Birth_____

Insured's Name: _____Relationship: _____ Insured's Date of Birth _____

PRIMARY CARE PHYSICIAN INFORMATION

Physician's Name: _____

Street Address: _____ Phone Number: _____

City, State, Zip Code: _____ County: _____

Email Address: _____@_____

Answer ALL questions

PERSONAL GOALS: (working with our clinic): Select ANY/ALL that apply to you

☐ Improve health (e.g., feel better, improve mobility, decrease medications, lower blood pressure, lower blood sugars, etc.)

_____

☐ Prevent disease(s) (e.g., diabetes, heart disease, etc.) _____

☐ Become eligible for a specific surgery (e.g., knee replacement): (fill-in-blank) _____

☐ Achieve a specific weight target: (fill-in-blank) _____ pounds

☐ Other (specify – e.g., increase fertility): _____

☐ What kind of changes would you be willing to start with?_____

☐ What kind of help would you like to meet your goals? _____

HISTORY: (Please list)

☐ Your highest weight? _____

☐ Your lowest weight? _____

☐ How many times a day do you eat? _____

☐ Physical Activity? _____

☐ Family history of being overweight? _____

☐ Family history of Diabetes, Genetic disorders, Cancer etc.? _____

☐ Weight Loss Program (without the use of short-term weight loss medications)

_____

☐ How many failed attempts? 0 ☐ 1-3 ☐ 4 or more ☐

☐ How many successful attempts? 0 ☐ 1-3 ☐ 4 or more ☐

☐ Weight Loss Medications? _____

☐ Over the counter medications?_____

☐ Prescription medications? _____

☐ Have you ever had weight loss surgery? _____

☐ Do you have a history of substance or alcohol abuse? ☐ Yes ☐ No

☐ Do you currently abuse substances or alcohol? ☐ Yes ☐ No

BARRIERS: (to achieving health/weight goals): Select ANY/ALL that apply to you

☐ None; not sure _____

☐ What has caused you to gain weight in the past? _____

☐ Do you have a history of eating disorders? _____

☐ Eating disorders: ☐ Binge eating ☐ Bulimia ☐ Anorexia ☐ Do you eat Argo Starch

☐ Other eating disorders: _____

☐ Diet, what types of foods do you eat? (e.g., fast foods, premade, homemade, etc.) _____

☐ Dietary knowledge, (food choices, portion sizes, etc.)? _____

☐ Hunger and/or cravings?_____

☐ Eating triggers (e.g., emotions, stress, boredom, etc.) _____

☐ Behavioral/schedule challenges (e.g., travel, work schedule, social calendar, etc.)_____

☐ Medical condition(s) (e.g., diabetes, mood disorder, cancer etc.) _____

☐ Medication(s) (e.g., insulin, antidepressants, steroids, etc.) _____

☐ Do you have any food allergies or intolerances? _____

☐ Other (specify): (fill-in-blank) _____

☐ How confident are you that you can follow a weight loss program?

☐ Very confident ☐ Moderately confident ☐ Only a little confident ☐ Not confident at all