First Name:______________________________
Middle Initial___ Last Name:_________________________

E-mail

Please indicate the best number to reach you and leave a message.
(_______)_____________-____________________ Cell Home Work

Employment status ☐Employed ☐Not Employed ☐Retired

Employer:____

Please provide your Primary Care Physician's information

Physician Name:_________________________________ Phone:(________)_________-_______________

Practice Name____

Address:____

City:_____________________________________State:_____________________Zip:________________

Why did you decide it was time to lose weight and consider weight management?

☐ Deteriorating health
☐ Poor quality of life
☐ Unable to participate in family activities
☐ Advise of physician
☐ Insurance/monetary issues
☐ Other If other, please specify below:
____

Co-morbid/medical conditions

Have you been diagnosed or treated for the following by a physician?

☐ Diabetes
☐ Sleep Apnea
☐ High Blood Pressure
☐ Cardiovascular Problems
☐ Gastric or Stomach Problems
☐ Heart Burn/Acid Reflux
☐ Joint Degeneration
☐ Depression

Any other medical conditions that you have been diagnosed or treated for?____________________________
____

Is there anything else you would like to share that you feel might be applicable?_________________________
____
____

WEIGHT HISTORY SECTION

Unsupervised diet attempts that you did on your own. (Check all that apply and enter the weight lost, weight regained, duration of time spent following the diet and number of attempts)

☐ No unsupervised diet attempts of any kind.

Diet Type	YES	NO	HOW MUCH WEIGHT DID YOU LOSE
○ Physician Supervised	________	_______	________lbs.
○ Nutri-Systems	________	_______	________lbs.
○ Optifast	________	_______	________lbs.
○ Weight Watchers	________	_______	________lbs.
○ Jenny Craig	________	_______	________lbs.
○ Other 1:_____________	________	_______	________lbs.
○ Other 2:_____________	________	_______	________lbs.

Eating Schedule **Breakfast** **Lunch** **Dinner**

Breakfast	Regularly	Sometime
Lunch	Regularly	Sometimes
Dinner	Regularly	Sometimes

Snacks Regularly Sometimes

Snacks how many times per day____

Eating Habits

- □ Scheduled meal eater
- □ No set schedule
- □ Binge eating/compulsive eater
- □ Emotional eater
- □ Night eater
- □ Other_________________
- □ Rapid eater
- □ Junk food eater
- □ Meat and potatoes type
- □ Sweet eater
- □ Fast food eater
- □ Large/multiple servings

1. **Why do you eat?** (check one or more)
   - □ Physical hunger
   - □ Boredom
   - □ Out of emotion/sad or depression
   - □ Sight and/or smell of food
   - □ Cravings □ Salty □ Sweet □ Memory triggered foods
   - □ Other ____________________

2. **Activity:** (check one)
   - □ Restricted (Explain____)
   - □ Sedentary
   - □ Low active
   - □ Active
   - □ Very active

3. **What reasons do you feel contribute to you being overweight?** (check all that apply)

□ Inactivity
□ Emotional well-being
□ Overconsumption
□ Eating too fast
□ Medications
□ Skipping meals and then overeating
□ Eating oversized portions
□ Eating when bored
□ I always clean my plate
□ Grazing/snacking
□ Too many sweets/starches
□ Eating on the run
□ Eating as a self-reward
□ Eating for comfort
□ Can't tell when you have eaten enough
□ Other:____________________________

4. Weight Loss Goals and Expectations

What goals would you like to set for yourself?____

Is there any additional information or comments you would like to share?______________________________
____
____

Signature____ Date____________________

By signing above, you agree that all information provided is accurate to the best of your knowledge.

Clinic Representative Signature____
Date________________