****

**Patient’s Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Today’s Date**:\_\_\_\_\_\_\_\_\_\_\_

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #1:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#2:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Gender** :  Male  Female

**Height**:\_\_\_\_\_\_\_\_\_\_\_ **Current Weight/ pant size**:\_\_\_\_\_\_\_\_\_\_\_\_ **Desired Weight:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance details (please include name group and certificate** :\_\_\_\_\_\_\_\_\_\_\_\_ **\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referred By**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Primary Doctor**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Married Not Married **Children:** Yes No Age of children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pregnant** Yes No **Breastfeeding :** Yes No

**Employed**  Yes  No Job:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Shift work:  Yes  No

**Diagnosed medical conditions:**  Obesity Hypertension  High Cholesterol Pre-diabetes

Diabetes Constipation Cancer Diarrhea GERD Anemia Kidney Stones

Other medical condition:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications(attach list if needed**)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Supplements:** Multivitamin Vit D Iron Vit B12 Calcium Magnesium

**Other supplements (provide sheet if necessary):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Food allergies:**  Yes  No: Fish Shellfish Nuts Wheat Milk Soy Gluten

**Lactose Intolerance:**  Yes No **Medication Allergies**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Special Diets:** Vegetarian Vegan Pescatarian other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How many days in a week do you eat out or buy take-out food?**

Everyday  5-6  3-4  1-2  Rarely

**Most common takeout: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Who buys the groceries?**  Self  Spouse  Parent  Son/Daughter  Other

**Who cooks the food**?  Self  Spouse  Parent  Son/Daughter  Other

**Most common cooking Method:**  Pan-fry  Deep-fry  Air-fry  Grill  Baked  Steam

**Do want to learn how to read nutrition labels?** Yes No

**Have you succesfully lost weight before?** Yes No If yes, how and when:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Meals per day:** ¨ 3 ¨ 2 ¨ 1 **Any** **Skipped?:** ¨ Breakfast ¨Lunch ¨Dinner **Snacks:** ¨ 1 ¨ 2 ¨ 3

**Fruits** ¨ None ¨ 1-2/week ¨ 3-4/week ¨ 5-6/week ¨ Daily

**Vegetables** ¨ None ¨ 1-2/week ¨ 3-4/week ¨ 5-6/week ¨ Daily

**Oil** ¨ Canola ¨ Olive ¨ Corn ¨ Vegetable ¨ Butter/Lard

**What do you drink per day(***leave blank if you do not consume any***):**

**Water** ¨ 1 bottle/16oz ¨ 2 bottles/32oz ¨ 3 bottles/48oz ¨ 4 bottles/64oz More: \_\_\_

**Soda** ¨ 1 bottle/16oz ¨ 2 bottles/32oz ¨ 3 bottles/48oz ¨ 4 bottles /64oz

**Juice** ¨ 1 bottle/16oz ¨ 2 bottles/32oz ¨ 3 bottles/48oz ¨ 4 bottles /64oz

**Gatorade** ¨ 1 bottle/16oz ¨ 2 bottles/32oz ¨ 3 bottles/48oz ¨ 4 bottles /64oz

**Alcohol** ¨ None ¨ 1-2/week ¨ 3-4/week ¨ 5-6/week ¨ Daily

**Milk** ¨ Nonfat ¨ Reduced fat ¨ Whole ¨ Almond ¨ Soy ¨ Oat

**Diet Recall**

**Write down anything you ate or drank along with when you took any medications for any day within the**

**Last 2 days:**

**Breakfast:**

Day one:

Day two:

**Lunch:**

Day one:

Day two:

**Dinner:**

Day one:

Day two:

**Snacks/Beverages:**

**PHYSICAL ACTIVITY & SLEEP**

¨ Walking ¨ Jogging/Running ¨Dancing ¨ Biking ¨ Gym

¨ Weight training ¨ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often: ¨ None ¨ 1-2/week ¨ 3-4/week ¨ 5-6/week ¨ Daily

How long: ¨ less than 15 min. ¨ 15-30 min. ¨ 30-60 min. ¨ more than 60 min.

**What time do you go to sleep at night?** \_\_\_\_\_\_\_\_\_\_\_\_\_**What time do wake up in the morning?** \_\_\_\_\_\_\_\_\_\_\_\_\_

Hours of sleep: ¨ <7 ¨ 7-9 ¨ 10+

**Late night/Midnight snack:**  Yes  No most consumed Item:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**READINESS TO CHANGE QUESTIONNAIRE**

**Are you currently**  Not motivated at all  Somewhat motivated  Very motivated

Do you have a referral from your Doctor  Yes  No

**What do YOU think you most need to do for your optimal health?(choose up to 3 answers)**

Increase Water intake.  Increase Protein  Increase Physical activity  Decrease portion sizes  Decrease refined Carbohydrate intake  Decrease sweetened beverages

Decrease fat intake  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What do you most want from your coaching visits:**  accountability  knowledge  emotional support

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Return form to efitbda@gmail.com OR to EFIT 16 Point Finger Road, Paget Bermuda