****

**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