Weight Loss New Patient Intake Form

Welcome To Our Clinic! Please Fill Out The Following Information Thoroughly So The Doctor Can Let You Know If You Are A Case We Can Accept. Please Feel Free To Ask Any Questions If You Need Assistance. We Look Forward To Serving You!

Name: ____ Date: __________

Address: ____

City / State / Zip: ____

Home Phone: ______________________ Cell Phone: __________________

Email Address: ____

Birth Date: ____________________ Marital Status S M D W

How Were You Referred To This Office: _______________________________

Are you in good health at the present time to the best of your knowledge? Yes No

Are you under a doctor's medical supervision at this time? Yes No
If Yes, for what? ____

Are you taking any medications at the present time? Yes No
If Yes, what medications? ____
____

Do you take vitamin supplements? Yes No
If Yes, what do you take? ____
____

History of high blood pressure? Yes No

History of diabetes? Yes No

History of frequent headaches or migraines? Yes No
If Yes, how often? _________________ Medication? ___________________

History of constipation? Yes No

Serious injuries? Yes No
Details: ____

Surgeries? Yes No
Details: ____

Do you have a family history of:
- Diabetes? If Yes, Who? ____
- Heart Disease? If Yes, Who? ____
- Cancer? If Yes, Who? ____
- Stroke? If Yes, Who? ____

Nutritional Evaluation:

Present Weight: ___________ Height: ____________ Desired Weight:___________

When would you like to be at your desired weight?

Why do you want to lose weight? (Health Benefit? Appearance?) Please explain thoroughly:

____
____

When did you begin gaining weight? _______________________________________
Reason why? ____

What has been your maximum weight (non-pregnant) and when? _________________

Have you tried other weight loss programs? Yes No
If yes, which ones? ____

Were you successful with it / were you able to keep the weight off? Yes No
Please explain: ____

Is your spouse, fiancee or partner overweight? Yes No
By how much is he/she overweight? _______________________________________

How often do you eat out? ____

What restaurants do you frequent? ____

How often do you eat “fast foods”? ____

Food allergies? ____

Food dislikes? ____

Food cravings? ____

Do you eat because of emotions (explain)? _____________________________

Do you drink coffee or tea? Yes No If Yes, how much daily? _________________

Do you drink pop / soft drinks? Yes No If Yes, how much daily? ______________
Do you use sugar substitutes? Yes No
If Yes, what? ____

What are your worst food habits? ___________________________________
____

Snack habits:
What: ____
How Much: ____
When: ____

When there is increased stress in your life, do you tend to eat more? Yes No
Explain: ____

Typical Breakfast:
What: ____
When: ____

Typical Lunch:
What: ____
When: ____

Typical Dinner:
What: ____
When: ____

Describe your energy level? _______________________________________

Activity Level: (check one)

_________ Inactive
_________ Light Activity
_________ Moderate Activity
_________ Heavy Activity
_________Vigorous Activity

On a scale of 1 to 10 with 10 being **MOST** committed, how committed are you to taking action and making a change in your life today? 1 2 3 4 5 6 7 8 9 10