New Patient Weight Loss Intake Form

Name: _____ **Date:** _____ dd / mm / yyyy

Street Address: _____ **City:** _____

State: _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Email Address: _____

Sex

◯ M ◯ F

Birth Gender

◯ M ◯ F

Birth date: _____ dd / mm / yyyy **Height:** _____

Weight: _____

Race (ie. White, Asian, African American):

Hispanic or Latino

◯ Yes ◯ No

Marital Status

- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Separated
- ☐ Divorced

Occupation: _____ **How did you hear about us?:** _____

Primary Care Physician: _____ **Primary Care Physician Phone:** _____

Emergency Contact: _____ **Emergency Contact Phone:** _____

Emergency Contact Relationship: _____

HEALTH AND WELLNESS HISTORY

Has your doctor advised you to lose weight?

Do you have any dietary restrictions?

◯ Yes ◯ No

Please explain

How often do you exercise?: _____ **What type of exercise?:** _____

Do you feel stressed?

◯ Yes ◯ No

Please explain

Check ALL that apply to you

- ☐ Pregnant
- ☐ Might Be Pregnant
- ☐ Breast Feeding
- ☐ Currently Undergoing Chemotherapy

What changed that caused the weight gain (if anything)?

What's the main reason you are seeking treatment at this time?

What are your goals about weight control and management?

What do you consider to be your ideal weight?

When was the last time you were at your ideal weight?

How much weight do you want to lose?

How many times a year do you diet?

What is the hardest part about managing your weight?

What have you tried in the past that has failed?

Weight Watchers - Date: _____

Weight Watchers - Medication: _____

Weight Watchers - Dose/Freq: _____

Liquid Diets - Date: _____

Liquid Diets - Medication: _____

Liquid Diets - Dose/Freq: _____

Keto Diet - Date: _____

Keto Diet - Medication: _____

Keto Diet - Dose/Freq: _____

Diet Pills (Phen-Fen) - Date: _____

Diet Pills (Phen-Fen) - Medication: _____

Diet Pills (Phen-Fen) - Dose/Freq: _____

Nutrisystem/Jenny Craig - Date: _____

Nutrisystem/Jenny Craig - Medication: _____

Nutrisystem/Jenny Craig - Dose/Freq: _____

Surgery - Date: _____

Surgery - Medication: _____

Surgery - Dose/Freq: _____

Have you maintained weight loss for up to a year with any of these programs?

What did NOT work for you about these programs?

What has been your lowest weight as an adult?:

What has been your highest weight as an adult?:

What's more important inches lost or pounds?

What's more important, fast or permanent?

How fast do you want to be slim, trim and fit?

What would stop you from a weight loss program?

Do you binge eat?

◯ Yes ◯ No

Do you suffer from uncontrollable cravings?

◯ Yes ◯ No

Do you feel that food controls you?

◯ Yes ◯ No

Do you eat because of your emotions?

◯ Yes ◯ No

Do you eat between meals?

◯ Yes ◯ No

What do you choose to eat between meals?

Do you feel that your eating behaviors are normal?

◯ Yes ◯ No

Briefly describe your daily eating behaviors

Does your family support your weight loss efforts?

◯ Yes ◯ No

Can you remember being at your ideal weight?

◯ Yes ◯ No

What do you remember most about it?

Commitment to weight loss: (please rate): (low) 1 2 3 4 5 6 7 8 9 10 (high)

◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯

1 2 3 4 5 6 7 8 9 10

What is the most important element in deciding to use our services?

◯ EFFECTIVENESS ◯ TIME ◯ SERVICE ◯ AFFORDABILITY

Check the following conditions you would like help with or more information on

- ☐ Weight Loss
- ☐ Knee Arthritis
- ☐ Hormone Balancing
- ☐ Insomnia
- ☐ Neuropathy
- ☐ Quitting Smoking
- ☐ Fatigue
- ☐ Diabetic Educ.
- ☐ Thyroid
- ☐ Memory & Mood
- ☐ Immune Boosting
- ☐ Pain Relief
- ☐ Joint Pain
- ☐ Stress Relief
- ☐ General Wellness
- ☐ Fitness

Drug Name 1: _____ **Dosage 1:** _____

How long have you taken & for what conditions? 1

Drug Name 2: _____ **Dosage 2:** _____

How long have you taken & for what conditions? 2

Drug Name 3: _____ **Dosage 3:** _____

How long have you taken & for what conditions? 3

Drug Name 4: _____ **Dosage 4:** _____

How long have you taken & for what conditions? 4

Drug Name 5: _____ **Dosage 5:** _____

How long have you taken & for what conditions? 5

Drug Name 6: _____ **Dosage 6:** _____

How long have you taken & for what conditions? 6

Drug Name 7: _____ Dosage 7: _____

How long have you taken & for what conditions? 7

Drug Name 8: _____ Dosage 8: _____

How long have you taken & for what conditions? 8

Drug/Food Allergy Name 1: _____

Reaction 1

Drug/Food Allergy Name 2: _____

Reaction 2

Drug/Food Allergy Name 3: _____

Reaction 3

Check ALL medical conditions that you may have had or currently have now

- [ ] ADD/ADHD
- [ ] Hepatitis
- [ ] Alcoholism
- [ ] High Blood Pressure
- [ ] Allergy
- [ ] High Cholesterol
- [ ] Alzheimer's
- [ ] High Blood Sugar
- [ ] Anemia
- [ ] HIV/AIDS
- [ ] Appendicitis
- [ ] Irritable Bowel
- [ ] Asthma
- [ ] Kidney Infect./stones
- [ ] Arthritis
- [ ] Low Blood Pressure
- [ ] Cancer
- [ ] Low Blood Sugar
- [ ] Celiac Disease
- [ ] Lyme Disease
- [ ] Chronic Fatigue
- [ ] Lupus
- [ ] Migraine
- [ ] Depression
- [ ] Miscarriage
- [ ] Diabetes
- [ ] Multiple Sclerosis
- [ ] Eczema
- [ ] Parkinson's
- [ ] Emphysema
- [ ] Pneumonia
- [ ] Epilepsy/seizures
- [ ] Raynaud's
- [ ] Fibromyalgia
- [ ] Rheumatoid Arthritis
- [ ] Gall Bladder
- [ ] Ringing in ears
- [ ] Goiter
- [ ] Sinus Infection
- [ ] Gout
- [ ] Stroke
- [ ] Heart Attack
- [ ] Thyroid Problems
- [ ] Heart Disease
- [ ] Ulcers
- [ ] Vertigo/Dizziness

Other medical conditions

Please list all previous surgeries & dates

Alcohol use?

◯ Yes ◯ No

Amount: _____

Alcohol frequency

◯ Daily ◯ Weekly ◯ Socially

Tobacco use?

◯ Yes ◯ Never ◯ Former Smoker

PPD: _____ **How many years?:** _____

I understand that my private healthcare information is protected under HIPPAA Privacy Regulations.

May we leave a message for you on your answering device?

◯ Yes ◯ No

I fully understand that my signature is consent and authorization to be examined by the Center for Wellbeing medical team. I understand that my entire patient history will remain completely confidential and will not be released without express written consent from me.

Patient Signature
Date: _____ dd / mm / yyyy

We understand that situations arise in which you must cancel your scheduled appointment. It is therefore requested that if you must cancel your appointment you provide a 24 hour notice. Appointments which are cancelled within less than 24 hour notice may be subject to pay the full balance owed at the time of cancellation. Cancellation and no show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. We understand that unavoidable circumstances may cause you to cancel with less than a 24-hour notice, fees may be waived upon management approval. Our practice firmly believes that good physician/patient relationships are based upon understanding and good communication. Questions about cancellation and no show fees can be directed to the front desk at (603) 380-9159.

Patient Name (Please Print): _____ **Date:** _____ dd / mm / yyyy

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Signature of Patient
Date: _____ dd / mm / yyyy