Remember to bring completed **Questionnaire** to your *Initial Consultation*

INTAKE QUESTIONNAIRE

No one likes questionnaires, but we invite you to consider this one as exceedingly important. It enables us to analyze the complex causes of your overweight status. Please take the time to answer all questions completely.

Name_________________________________ Date__________
Last First

Address_______________________________ Home Ph. (___) ___-_____
No. Street Apt

_______________________________ Work Ph. (___) ___-_____
City State Zip

Date of Birth__ /___/____ e-mail ______________ Cell Ph. (___) ___-_____

How were you referred to this office? _______________________________________

Who is your primary care provider? _______________________________________

List any other physician you see and for what problem:

__________________________________ for _________________________________

__________________________________ for _________________________________

__________________________________ for _________________________________

MEDICAL AND WEIGHT INFORMATION

What do you consider the state of your overall health?
□Good □Average □Below Average □Poor

Your weight at H.S. graduation____ Age 21____ Highest Wt ____Current Wt____
Current Height_____ What is your target weight now? _______

Has your weight come on slowly (over years) or rapidly (a few months)? _______

At what **age** did you first start having a weight problem? ______

Why do you think you have gained weight? _________________________________

____

List your previous attempts to lose weight. Include which approaches helped and which did not.

____

____

What factors may have contributed to your regaining of weight?

____

____

List any weight loss medications you have used in the past. Include whether prescription or non-prescription, which helped the most and the least. List how long you took it and about how much you lost.

Medication	Helped?	How long?	How much lost?
____________________	_________	_________	________________
____________________	_________	_________	________________
____________________	_________	_________	________________

If you used phen/fen (fenfluramine, dex-fenfluramine, Pondimin, or Redux), have you had an echocardiogram? _____If so, what were the results?______________

PAST MEDICAL HISTORY

Check any conditions you currently have or that you have had in the past:

- □ Heart attack/angina
- □ High blood pressure
- □ Diabetes
- □ Stroke
- □ High cholesterol/ triglycerides
- □ Gout
- □ Epilepsy
- □ Chronic fatigue syndrome
- □ Gastro-esophageal Reflux
- □ Fertility problems
- □ Significant acne
- □ Fibromyalgia
- □ Drug abuse
- □ Glaucoma
- □ Headaches
- □ Liver disease
- □ Muscle weakness
- □ Discolored lines on skin
- □ Easy bruising
- □ Rheumatoid arthritis
- □ Mood swings
- □ Other joint problems
- □ Thyroid disease
- □ Kidney disease
- □ Cancer, If so, what type? _______________
- □ Shortness of breath
- □ Sleep apnea
- □ Snoring
- □ Poor sleep
- □ Hard to fall asleep
- □ Asthma
- □ Depression
- □ bipolar disease
- □ Heartburn
- □ Osteoarthritis
- □ Lupus
- □ Constipation
- □ Sleep apnea syndrome

Women only:

- □ Polycystic ovary disease
- □ Excessive facial/body hair
- □ Significant PMS
- □ Infrequent/Irregular periods
- □ Breast secretions

Men only:

- □ Enlarged Prostrate

Surgical history: List any surgeries you have had:
____
____

Medications:
List any **medications** that you currently use:

_________________________ _____________________
_________________________ _____________________
_________________________ _____________________

List any other over-the-counter or herbal supplements you are currently taking:

_________________________ ______________________
_________________________ ______________________

List any medications that you are **allergic** to: _______________________________

Tobacco and Alcohol Use
Do you use tobacco products? □Yes □ No How much each day? _______ packs(s)
How many beers, glasses of wine, or cocktails do you drink?
□ none □ 1-2 a month □1-2 a week □ 1-2 a day □ 3 or more a day

FAMILY HISTORY

Check any conditions affecting a **blood relative** (mother, father, sibling, child, aunt, uncle, grandparent). Please list who has or had the problem.

□ Heart attack _________ □ Under active thyroid ________ □ Stroke _____________

□ Diabetes _________ □ High blood pressure ________ □ Gout ___________

□ Depression ________ □ Alcohol abuse _________ □ High cholesterol _____

□ Obesity/overweight______________ □ Polycystic ovary disease _______________

Exercise

Which best describes you? □ I used to exercise but haven't recently.
□ I have never really liked exercise / I have to struggle to get myself to.
□ I am currently exercising on a regular basis.
If you do exercise, what exercise are you now doing on a regular basis?
_______________________________ Hours per week? __________

When were you the most physically active as an adult? ____________________

What was your exercise pattern at that time? ____________________________

What physical activity do you enjoy the most? ___________________________

Have you had any specific injuries that limit your exercise activities? □ Yes □ No
If so, what? ____

Are there any health barriers to your doing exercise right now? _________________
If so, what? ____

Eating/Sleeping/Work Patterns

Which meals do you eat nearly every day? Give times and typical contents of that meal. If you usually skip the meal, indicate that.

□Breakfast ____

□Mid morning snack _____________________________________

□Lunch ____

□Mid-afternoon snack ____________________________________

□Dinner ____

□Evening snack____

How many hours do you work per week? ____What is your commute to work? ______
When do you start and finish work each day?

Sunday _____________
Monday_____________ Thursday___________
Tuesday_____________ Friday ______________
Wednesday_________ Saturday______________

What type of work do you do?
____
What time do you go to sleep? _______. What time do you usually get up? ______
How many hours do you sleep? ______
Do you snore? _____. Does it actually interrupt your sleep? _____

Are you likely to change jobs over the next 12 months? □ no □ maybe □ yes
Are you planning to move during the next 12 months? □ no □ maybe □ yes
Is there any serious or life-threatening illness in your immediate family? Who and what?
____

Is there a particular time of day when you find it hardest to avoid overeating or to avoid eating “bad” food choices?_______________ When is that?__________________

Which foods do you find it hardest to resist? (Check all that apply)

□ candy □ alcoholic beverages □chocolate
□ ice cream □ soda pop – non diet □ cheese
□ cookies, cakes, muffins, etc. □ fats, chips, dressings, fried foods sauces
□ carbs: popcorn, bagels, bread, pasta, crackers, potatoes, corn, rice etc.

□ other ____

Do you have lactose intolerance? _______ □ yes □ no

Does milk (dairy products) upset your stomach, give you gas or cause diarrhea?

Is there a particular situation in which you are more likely to over eat even though **you're not really hungry?** What situation?________________________________

Are you most likely to reach for (circle those that fit you):

salty foods fatty foods carbs sweets crunchy foods

Is the **amount of food (volume)** a problem? Do you go back for seconds? Are your portions large? □ yes □ no

Is there a food that really throws you off your diet plans? (A food that if you stay away from completely, you do far better with your eating?) □ yes □ no

Which food(s), if so?

____

____

____

PSYCH-SOCIAL HISTORY

Thoughts about Food and Weight

Do you ever eat an unusually large amount of food in a short period?

□ no □ sometimes □ often

Do you feel out of control when you do so? □ no □ sometimes □ often

How many times per month could this happen? _____________ # of times a month.

Do you eat food in secret or hide the fact that you're eating

□ no □ sometimes □ often

Do you use vomiting, laxatives or exercise to compensate for overeating?

□ no □ sometimes □ often

Do you eat when you feel stressed, nervous, angry, bored or down in spirit*?* □*Yes* □ *No*

How often? □ never □ sometimes □ often

Do you think you eat enough for you to weigh what you do? □ yes □ no

What will make it most difficult for you to stay on track?

____

9811 Greenbelt Road - Suite 104 - Lanham MD 20706 - (301) 552-3956 – E-mail: info@rosebudweightloss.com

____

How serious is your weight problem? **Circle the level that fits**

not serious at all 0-----1-----2-----3-----4-----5-----6----7-----8-----9-----10 very serious life threatening

What is the single largest factor that is motivating you to lose weight at this time?
____

At this time, how important is it for you to lose weight and keep it off? Circle the level that fits

I want to lose weight 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 most important
If it's not too hard issue in my life

If it means you will loose weight and keep it off, how willing are you to:
Circle the level that fits for each activity

change your eating habits
would resist doing this 0-----1-----2-----3-----4-----5-----6-----7----8----9----10 very willing to do

shop for groceries
would resist doing this 0-----1-----2-----3-----4-----5-----6-----7----8----9----10 very willing to do

cook (and eat) at home
would resist doing this 0-----1-----2-----3-----4-----5-----6-----7----8----9----10 very willing to do

change your **exercise** habits
would resist doing this 0-----1-----2----3-----4-----5-----6-----7-----8----9-----10 very willing to do

rearrange your **schedule**
would resist doing this 0-----1----2-----3-----4-----5-----6-----7-----8-----9-----10 very willing to do

log food & exercise daily
would resist doing this 0-----1------2----3----4----5-----6-----7------8-----9-----10 very willing to do

Social Issues

Do you live alone or with others? ____

If you are in a relationship? □yes □no If so, what kind and how long?______________

Any significant strains or conflicts in that relationship, what are they?
____

Do you have children? □Yes □ No Ages____________________________________

Any special challenges with them? □Yes □ No If Yes, Explain:
____

How would you rate the current level of stress in your life at this time? Circle a level

NO stress 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 **Very high** stress

What is the greatest source of stress in your life right now, if any? ________________

How do you handle stress/worry/anxiety currently?_____________________________

Do you use food as a way to handle stress or to comfort yourself? □Yes □ No
How often do you do this? ____

If so, what do you say to yourself to justify this eating? (For example "It has been such a hard day, I deserve this treat…")

____

____

Do you have a support system in place to help you with this project? □ no □ yes

Is there anyone who may sabotage you in your efforts to lose weight? □ no □ yes

How good of a time is this for you to be starting a weight loss program? Circle a level
Worst time 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Best **time**

Is there one thing that you could do that you know would make a large difference in your weight situation? What is it? ____

Why do you think you don't make that change? __________________________________

Spiritual Issues

Where are you spiritually? (That is, do you have a faith/religion?) □ yes □ no If yes, which one and how active are you in this faith (e.g. how often do you attend services/involved in activities?

____

How do you see your purpose in life?

____

____

Who are you an example for? (e.g. "my child", "my younger brother") _________________

What do you foresee as our role in helping you in your efforts to lose weight? Please write anything else you would like us to know. *Be creative. Feel free to add another page),*

____

____