



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 Last First

Date

Address No. Street Apt City State Zip

Home Ph. () -

Work Ph. () -

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:

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

Women only:

- | | | |
|---|---|--|
| <input type="checkbox"/> Polycystic ovary disease | <input type="checkbox"/> Significant PMS | <input type="checkbox"/> Breast secretions |
| <input type="checkbox"/> Excessive facial/body hair | <input type="checkbox"/> Infrequent/Irregular periods | |

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?

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*,
