

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: _____

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

- | | |
|--|---|
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Knee Arthritis | <input type="checkbox"/> Memory & Mood |
| <input type="checkbox"/> Hormone Balancing | <input type="checkbox"/> Immune Boosting |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Pain Relief |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Quitting Smoking | <input type="checkbox"/> Stress Relief |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> General Wellness |
| <input type="checkbox"/> Diabetic Educ. | <input type="checkbox"/> 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

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

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

Signature of Patient

Date: _____ dd / mm / yyyy