Weight Loss Intake Form

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Welcome! Fill out the following information so we can plan the best program for success.

Name: (Last) _____ (First) _____ Sex ☐ M ☐ F

Date of birth: _____ Age _____ SSN _____

Address: _____

Phone number: _____ Email: _____

Employer: _____ Occupation _____

Emergency contact _____ Phone _____ Relationship _____

Who is your primary care physician (PCP)?

Name _____ Phone number _____

List ALL medications & supplements you take (prescription & over the counter)

Drug Name:	Dosage:	How long have you taken & for what conditions?

What diets/medications have you tried previously?

Drug Name:	Dose	Reason for discontinuing:

Allergies (including medication, food, and type of reaction): ☐ None

_____

_____

Please list all previous surgeries & dates:

_____

_____

Previous medical history (what have you been diagnosed with/medical problems you've had in the past):

_____

_____

_____

Current height: _____ Current weight: _____

What is your goal weight? _____

How much weight would you like to lose? _____

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:
Have you gotten your A1C checked? □ Yes □ No Do you have elevated glucose?
Check ALL that apply to you: □ Pregnant □ Might Be Pregnant □ Breastfeeding □ Currently Undergoing Chemotherapy
Relationship status □ Single □ Married □ Partnered □ Divorced □ Widow
Do you have children?

Family History - Please list any diseases that run in your family (ex heart disease, cancer, stroke, hypertension, low thyroid, arthritis, etc.)

Do you have migraine headaches? □ Yes □No
Have you had hormone testing/checked your thyroid? □ Yes □No
Do you have asthma? □ Yes □No
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)

Alcohol use? Yes / No Amount _____ Daily / Weekly / Socially
Tobacco use? Yes / Never / Former Smoker PPD _____ How many years? _____

Have you gotten any blood work done recently? _____
What were the findings? _____

Program	Date	Medication	Dose/Freq.
Weight Watchers			
Liquid Diets			
Keto Diet			
Diet Pills (Phen-Fen)			

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 _____ and highest _____ weight as an adult?