



## Weight Loss New Patient Intake Form

**Welcome To Our Clinic! Please Fill Out The Following Information Thoroughly So The Doctor Can Let You Know If You Are A Case We Can Accept. Please Feel Free To Ask Any Questions If You Need Assistance. We Look Forward To Serving You!**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City / State / Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Marital Status    S   M   D   W

How Were You Referred To This Office: \_\_\_\_\_

Are you in good health at the present time to the best of your knowledge?    Yes    No

Are you under a doctor's medical supervision at this time?    Yes    No  
If Yes, for what? \_\_\_\_\_

Are you taking any medications at the present time?    Yes    No  
If Yes, what medications? \_\_\_\_\_

Do you take vitamin supplements?    Yes    No  
If Yes, what do you take? \_\_\_\_\_

History of high blood pressure?    Yes    No

History of diabetes?    Yes    No

History of frequent headaches or migraines?    Yes    No  
If Yes, how often? \_\_\_\_\_ Medication? \_\_\_\_\_

History of constipation?    Yes    No

Serious injuries? Yes No  
Details: \_\_\_\_\_

Surgeries? Yes No  
Details: \_\_\_\_\_

Do you have a family history of:

- Diabetes? If Yes, Who? \_\_\_\_\_
- Heart Disease? If Yes, Who? \_\_\_\_\_
- Cancer? If Yes, Who? \_\_\_\_\_
- Stroke? If Yes, Who? \_\_\_\_\_

**Nutritional Evaluation:**

Present Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Desired Weight: \_\_\_\_\_

When would you like to be at your desired weight?

Why do you want to lose weight? (Health Benefit? Appearance?) Please explain thoroughly:

\_\_\_\_\_  
\_\_\_\_\_

When did you begin gaining weight? \_\_\_\_\_  
Reason why? \_\_\_\_\_

What has been your maximum weight (non-pregnant) and when? \_\_\_\_\_

Have you tried other weight loss programs? Yes No  
If yes, which ones? \_\_\_\_\_

Were you successful with it / were you able to keep the weight off? Yes No  
Please explain: \_\_\_\_\_

Is your spouse, fiancée or partner overweight? Yes No  
By how much is he/she overweight? \_\_\_\_\_

How often do you eat out? \_\_\_\_\_

What restaurants do you frequent? \_\_\_\_\_

How often do you eat "fast foods"? \_\_\_\_\_

Food allergies? \_\_\_\_\_

Food dislikes? \_\_\_\_\_

Food cravings? \_\_\_\_\_

Do you eat because of emotions (explain)? \_\_\_\_\_

Do you drink coffee or tea? Yes No If Yes, how much daily? \_\_\_\_\_

Do you drink pop / soft drinks? Yes No If Yes, how much daily? \_\_\_\_\_

Do you use sugar substitutes? Yes No

If Yes, what? \_\_\_\_\_

What are your worst food habits? \_\_\_\_\_

Snack habits:

What: \_\_\_\_\_

How Much: \_\_\_\_\_

When: \_\_\_\_\_

When there is increased stress in your life, do you tend to eat more? Yes No

Explain: \_\_\_\_\_

Typical Breakfast:

What: \_\_\_\_\_

When: \_\_\_\_\_

Typical Lunch:

What: \_\_\_\_\_

When: \_\_\_\_\_

Typical Dinner:

What: \_\_\_\_\_

When: \_\_\_\_\_

Describe your energy level? \_\_\_\_\_

Activity Level: (check one)

\_\_\_\_\_ Inactive

\_\_\_\_\_ Light Activity

\_\_\_\_\_ Moderate Activity

\_\_\_\_\_ Heavy Activity

\_\_\_\_\_ Vigorous Activity

On a scale of 1 to 10 with 10 being **MOST** committed, how committed are you to taking action and making a change in your life today? 1 2 3 4 5 6 7 8 9 10