CLEAR

Why Weight, LLC
7325 S. Pierce St, Suite 102
Littleton, CO 80128

Date: _____

HEALTH QUESTIONNAIRE

Name: _____ Phone (H): _____ (W): _____ (C): _____

Address: _____ City: _____ State: _____ Zip Code: _____

Birthdate: _____ Age: _____ Sex: _____ Marital Status (S,M, W, D): _____ Referred by: _____

Employer and Position: _____ Hours: _____

Spouse/Partner's Occupation and Position: _____

Height: _____ Present weight: _____ Wt at age 18: _____ Desired Wt: _____ Highest wt (non-pregnant) & date: _____

Yes	No		Have you ever had:	Highest BMI _____ & Adjusted BMI _____
○	○	1.	Rheumatic fever, heart disease, high blood pressure, cancer, diabetes, gout, tuberculosis, kidney problems, blood clots, or other serious diseases?	Briefly explain each yes answer below & indicate the number of the question for each response.
○	○	2.	A family history of diabetes, heart trouble, high blood pressure or weight problems?	
○	○	3.	Surgery or serious injury?	
○	○	4.	Problems with your stomach or bowels, such as persistent indigestion, constipation, diarrhea, ulcers or gall bladder trouble?	
○	○	5.	Problems with your kidneys or bladder, such as trouble urinating, frequent urination or burning?	
○	○	6.	Menstrual problems such as cramps, irregularity, spotting, hot flashes, depression or indications of change of life? Date of last Pap (cancer) smear?	
○	○	7.	Problems with heart or lungs, such as shortness of breath, chronic cough, chest pain, rapid or irregular heart beat?	
○	○	8.	Problems sleeping such as getting to sleep or staying asleep?	
○	○	9.	Have you had a problem sleeping that required treatment with prescribed or over the counter sleep aids? Please list.	
○	○	10.	Problems with excessive snoring, sleep apnea or restless legs? Please list any treatment.	
○	○	11.	Problems with swelling of the hands or feet?	
○	○	12.	Arthritis, joint or back problems?	
○	○	13.	Are you taking medication at this time? (Including birth control pills) Please list.	
○	○	14.	Are you allergic to any medications? Please list allergic symptoms.	
○	○	15.	Have you been treated for nerves, depression, psychiatric problems, or attempted suicide? Please explain. When? _____	
○	○	16.	Have you ever had an eating disorder, such as anorexia or bulimia? Please explain.	
○	○	17.	Have you taken weight medications or been treated by a doctor previously for your weight? Explain when and your results.	
		18.	Date of last complete physical _____ Name of PCP _____	
		19.	Number of years overweight _____ PCP Phone _____	
		20.	Weight 6 months ago _____ 1 year ago _____	
		21.	State amount used each day: alcohol/beer _____ Coffee/tea _____ recreational drugs _____ cigarettes _____ Sugar drinks, soda, energy drinks _____	
○	○	22.	Do you exercise? If yes: minutes/day _____Days /wk _____ Type of exercise:	

Please write out a typical days food intake (including beverages etc.)

Breakfast:_____

Mid-morning: _____

Lunch: _____

Mid-afternoon: _____

Dinner: _____

Evening snack: _____

Patient Signature: _____

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WEIGHT HISTORY QUESTIONNAIRE

Name: _____

1.	**Is it your decision to lose weight your own, or for someone else? Please explain.**
2.	**What are your goals about weight management and control?**
3.	**What is the hardest part about managing your weight?**
4.	**What do you believe will be of most help to assist you in losing weight?**
5.	**Are you ready to for lifestyle changes to be a part of your program? If yes, please list.**
6.	**Who is your primary support system? How will they provide you with support during your journey?**
7.	**Are there events in your life right now that might make losing weight especially difficult? Please explain.**

As best as you can recall, what was your weight at each of the following time points (if they apply).

Grade school _____ High School _____College _____ Ages 20-29 _____ 30-39 _____ 40-49 _____ 50-59 _____

What has been your lowest weight as an adult? _____ At what age did you start trying to lose weight? _____

Please check all previous programs you have tried in order to lose weight. Include dates and length of participation.

Programs	**Date**	**Weight (lost or gained)**	**Length of Participation**
• TOPS	_____	----- _____ lbs	_____
• Weight Watchers	_____	----- _____ lbs	_____
• Overeaters Anonymous	_____	----- _____ lbs	_____
• Liquid Diets (i.e. Optifast)	_____	----- _____ lbs	_____
• RX Diet pills	_____	----- _____ lbs	_____
• NutriSystem/Jenny Craig	_____	----- _____ lbs	_____
• OTC diet pills	_____	----- _____ lbs	_____
• Obesity Surgery	_____	----- _____ lbs	_____
• Registered Dietician	_____	----- _____ lbs	_____
• Weight loss retreat	_____	----- _____ lbs	_____
• Other: _____	_____	----- _____ lbs	_____

Have you maintained any weight loss for up to 1 year on any of these programs? ◯ YES ◯ NO

What did you learn from these programs regarding your weight? _____

What did not work about these programs? _____

Have you been involved in physical activity programs to help with weight loss? ◯ YES ◯ NO

Which ones or in what way? _____

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PHYSICAL EXAMINATION

☐ Initial ☐ Repeat

Patient Name: _____ DOB: _____ Date: _____ Sex: F M

Blood Pressure: _____ /_____ Left Arm Right Arm Pulse: _____ /min NSR Other ☐

ITEM	Normal	Abnormal	Not Examined	Appears >age ☐ =age ☐ <age ☐
1. Appearance/Cushingoid				
2. Skin/Color, Turgor, Lesions				
3. Upper Extremities/Hands				
4. Head/Hair, Scalp, Cranium				
5. Neck/Nodes/Ant Cervical, Auricular, Occipital, Post Cervical, Supraclavicular, Thyroid				
6. Eyes/Acuity, Sclera, Cornea, Lids, EOM, PERLA				
7. Ears/Acuity				
8. Nose, Sinus Tenderness				
9. Pharynx/Lips, Tongue, Teeth, Gums, Tonsils				
10. Chest/Lungs, Motion, Clear				
11. Heart/Apical Impulse, Precordium, Auscultation, Murmur, Rub				
12. Abdomen/Tenderness, Masses				
13. Legs & Feet/Skin, Hair, Edema, Tenderness, Vericosities, Cellulite, Ulcers				
14. Musculo-skeletal/ROM, Strength, Joints				
15. Neurological/Sensory, Motor, Cerebellar				
16. Mental Status/Affect, Perceptions, Speech, Judgment, Insight, Thinking				

Diagnosis: _____

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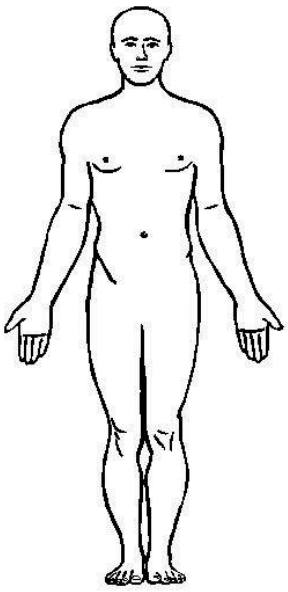

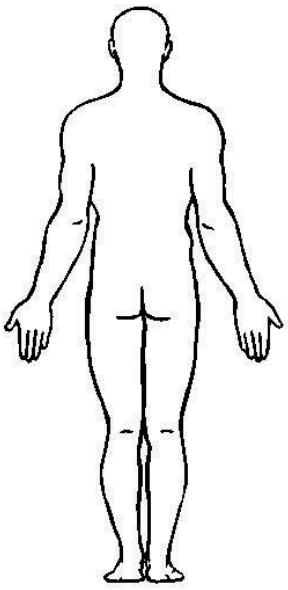

Practitioner's Initials: _____