HEALTH & LIFESTYLE QUESTIONNAIRE

Please provide the following information to assist us in determining your eligibility for our programs and accessing your needs for long term weight loss success. Please answer all questions to the best of your ability.

All information is strictly confidential.

PERSONAL INFORMATION

Name____ Preferred Phone#_________________________

Email____

Street Address_____________________________ City_______________________ State_____ Zip_________

Age_______________ Height_____________ Date of Birth ________________________

How did you hear about us: Newspaper? _______________________ Our Website? _________________

Social Media?__________________________ If referred, by who? __________________________________

HEALTH HISTORY

Personal Physician__________________________ Location of Practice (city or town) ________________

Are you currently under a physician's care for acute medical treatment? **YES ___ NO ___**

If yes please describe.____
Please list any medication(s) you take and what they are for:

	Medications	Condition
1.	__________________________________	_____________________________
2.	__________________________________	_____________________________
3.	__________________________________	_____________________________
4.	__________________________________	_____________________________
5.	__________________________________	_____________________________

Do you have any Food Allergies? **YES NO** *If yes, please be specific:*___________________________

Circle if yes: Milk Soy Nuts Gluten (Latex)

Are you lactose intolerant? **YES NO**

	YES	NO	
Have you had gastric bypass surgery?	___	___	If yes, when? _________
Are you currently pregnant or breast feeding?	___	___	
Do you have an *active* ulcer?	___	___	
Do you have kidney disease or protein spillage?	___	___	
Do you have Type 1 Diabetes?	___	___	
Are you experiencing anorexia or bulimia?	___	___	
Do you have a drug or alcohol addiction?	___	___	

Please check if any of the following weight/nutrition related conditions apply:

	Diagnosed	At Increased Risk
Diabetes	________	_________
Hypertension	________	_________
High Cholesterol	________	_________
Depression	________	_________
Osteoporosis	________	_________
Sleep Apnea (CPAP)	________	_________

Have you had any of the following? *Please circle if current*:

YES	NO		YES	NO	
___	___	blood sugar swings	___	___	chest pain
___	___	heart disease/heart attack	___	___	back pain
___	___	high blood pressure	___	___	heartburn
___	___	gall bladder trouble	___	___	fatty liver
___	___	kidney trouble	___	___	cancer
___	___	dizziness/lightheaded	___	___	anxiety
___	___	hair loss	___	___	bloating
___	___	water retention	___	___	mood swings
___	___	constipation	___	___	irritable bowel
___	___	diverticulitis	___	___	PCOS
___	___	thyroid(hyper or hypo)	___	___	osteopenia
___	___	osteoporosis	___	___	ulcer
___	___	difficulty going to sleeping	___	___	difficulty staying asleep

Has your doctor or nurse practitioner recommended that you lose weight? **YES ___ NO ___**

Please rate your **energy** level on a scale from 1 – 10: _____________

Please rate the **quality of your sleep** on a scale from 1 – 10: __________

Please list any vitamins or minerals that you take (for example: multivitamin, Fish Oils, Vitamin C, Vit D) and *circle if they were recommended by your doctor:*

____

PART TWO

1. What is the single most important reason you are ready to start losing weight NOW? _____________
   ____

   Please check all others that apply:

   ____ Appearance
   ____ Tight clothes
   ____ General Health
   ____ Medical Condition or Medications
   ____ Doctor's suggestion
   ____ Upcoming event (Date ____________________________)
   ____ Self-esteem/relationship
   ____ Other: ____

2. How much do you currently weigh?________ lbs (check here if you do not know ______)

3. Have you put on weight in the past two years? **Yes ___No ___** *If yes*, how many pounds? ________

4. What was your heaviest weight ever? ___________

5. How much weight would you like to lose? ________

6. Current Dress/Slack Size_______ Desired Dress/Slack Size_____

7. How many clothing sizes do you currently have in your closet? ___________________________

8. What, if anything, have you tried previously to lose weight?

   ____ Exercise ____ Pills ____ Fasting ____ Diet: ___________________

9. How successful were you? ____ Very Good ____ Good ____ Average ____ Poor

10. Have you gained weight since then? **Yes _______ No ________** If yes, do you know why?

    ____

11. Assuming ALL of our programs provide rapid, safe weight loss – which of the following approaches sounds best to you?

    As Aggressive As Possible! Just make it quick and simple! **Yes ___No ___**
    Very Aggressive - but I want to eat grocery store foods **Yes ___No ___**
    I want to take it off steadily over time while learning good eating habits **Yes ___No ___**
    I want to lose weight but I get bored easily and need lots of variety **Yes ___No ___**

12. Do you take time to plan/cook your meals? **Yes ___ No ___**
    Or do you prefer fast food? **Yes ___ No ___**
    Or do you tend to skip meals? **Yes ___ No ___**

13. Do you currently follow an exercise routine? **Yes ___ No ___** How many times per week? _____

14. Which describes you best? I eat too much when: ____ nervous ___ bored ____ upset
    ____ with friends/family ____ Other: ____

15. When is it most difficult to control your eating?
    breakfast ___ mid a.m. ____ lunch ___ mid p.m. ____ dinner ____ nighttime ___ weekends ____

16. Do those close to you wish you would take part in a weight loss program? **Yes ___ No ___**
    If yes, who? ____

17. Will your family/friends help you diet? **Yes ___ No ___**
    If not, who will you turn to for support? ____

18. Does your spouse know that you are here today?

19. Does your schedule allow a few minutes once per week to visit us? **Yes __ No __**

20. Please list what you eat on a typical day *and at what time:*

Breakfast _____am	**Lunch _____pm**	**Dinner ____pm**
______________	______________	______________
______________	______________	______________
______________	______________	______________

Snacks _______	**Beverages _____**	**Desserts _____**
____________	____________	____________
____________	____________	____________

_____ *Who knows! I just graze all the time.*

21. What else should we know before designing your food plan??
    ____
    ____
    ____

Signature ______________________________________ Date ______________________