Weight History

Name: _____ Date of birth_____ Today's Date_____

Primary Physician_____ How did you hear about our program?_____

Maximum lifetime weight_____ Desired weight _____

Please circle all that apply:

How long have you been overweight? Since childhood / > 5years / < one year

What situation led to your weight gain? Stress / college / divorce / career change / pregnancy / menopause / medications / other_____

What weight loss methods have you tried before? Diet pills / Weight Watchers / surgery / diet & exercise / other_____

Dietary History (please list typical meals):

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Are you a night eater? (eating most of your calories after 5pm) YES / NO

When is your hungriest time of the day? Morning / Afternoon / Evening

How many times/week do you eat out? _____TYPE: Chinese / fast food / Indian / Italian / Mexican / other_____

How many sodas / diet sodas per day? _____

Exercise and Sleep:

Inactive (sedentary)_____ Light activity_____ Moderate activity _____ High level activity _____

What type of activity do you do now? _____

Do you suffer from sleep disturbances? If so, please explain_____

Please list all the current medications with dosages you are taking including over the counter:

Do you have any medication or food allergies? If so, please explain_____

Personal Medical History (Indicate by circling the following conditions):

diabetes	heart disease	thyroid disease	cancer	sleep apnea
high blood pressure	asthma	COPD	heartburn	eating disorder
high cholesterol	irregular heartbeat	arthritis	other_____	

Weight History

Family Medical History (Indicate by circling the following conditions):

diabetes heart disease thyroid disease cancer

high blood pressure high cholesterol other_____

Social History:

Highest degree of education: _____ *What is your occupation*? _____

Marital status: _____ *Do you drink alcohol*? _____ If so, how many per week _____

Use birth control? Yes / No *Are you trying to conceive?* Yes / No

Currently smoking? Yes / No Amount?_____ *Never smoked?* ____ *Quit Smoking?* ____ When_____

How often do you drink alcohol? Never / Rarely / 3-5x a wk / Daily / Weekends / On special occasions

Drug use? Yes / No Type _____ How often _____

History of Present Illness (Please list any health concerns you are having today):

_____

_____

_____

Weight Loss Resistance Questionnaire

Do you…

Metabolic switch / Insulin Resistance / Carb Sensitivity
Frequently crave sugar? Yes / No Have mood swings / energy fluctuations that influence your eating? Yes / No
Gain weight in your upper body or mid-section? Yes / No
Stress Eating
Have stress-induced cravings for salt, sugar, or fatty foods? Yes / No Eat carbs after a stressful day? Yes / No
Food Allergies
Have a history of frequent colic, ear infections, or food allergies? Yes / No Have irritable or irregular bowels? Yes / No
Suffer from nasal congestion, sinusitis, asthma, hives, or eczema? Yes / No
Have a muscle aches, joint pains, or chronic headaches? Yes / No
Night Eating Syndrome
Have sleep problems (trouble falling, staying asleep, fragmented sleep)? Yes No Have daytime drowsiness? Yes / No
Snore? Yes / No Take sleeping pills? Yes / No Skip breakfast? Yes / No
Eat most of you calories after 5pm? Yes / No Wake up at night to eat? Yes / No
Detoxification problems
Have fibromyalgia or chronic fatigue syndrome? Yes / No
Take NSAIDs (Advil, Ibuprofen), anti-depressants, steroids (prednisone), beta-blockers (atenolol, metoprolol), or psych meds? Yes / No
For Women Only
Experience craving and weight gain with PMS? Yes / No Have weight gain associated with menopause? Yes / No