



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 <i>active</i> 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 Doctor's suggestion
 Tight clothes Upcoming event (Date _____)
 General Health Self-esteem/relationship
 Medical Condition or Medications 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 _____