New Patient Questionnaire (Weight Loss Analysis)

First Name:	Last Name:	Email:
_____	_____	_____
Phone:	**Date of Birth:**	**Address:** _____
_____	_____	_____

Gender: ☐ **Male** ☐ **Female**

How did you hear about us?: _____

Office Use:_____ **Weight** _____ **Height**

_____ **BMI** _____ **Body Fat**

Please answer the following questions honestly so we can do our best to help you reach your goals

Who encouraged you to lose weight?: _____

How important to you is it to lose weight?: _____

What important reason, special occasion, or goal date do you have to lose weight?: _____

_____

How many pounds would you like to lose?: _____ How fast do you want lose the weight?: _____

Would you commit to one visit a week?: ☐ Yes ☐ No

Have you ever attended any other weight reduction centers, if so, which ones?: _____

What kinds of diets have you tried on your own?: _____

What is the longest you have been able to stick with a diet?: _____

Does your family support your weight loss efforts?: ☐ Yes ☐ No

Have you been advised by your family physician to lose weight?: ☐ Yes ☐ No

If you answered Yes, what is your doctor's name?: _____

Do you eat because of emotions?: ☐ Yes ☐ No

If you answered yes, please explain: _____

_____

On average, which of the following reflects your daily eating habits? (Please check all that apply):

- ☐ 3 meals with healthy snacks
- ☐ 3 meals
- ☐ 2 meals or less
- ☐ Skip breakfast or other meals
- ☐ Generally eat on the run
- ☐ No regular eating pattern
- ☐ Often crave sweets/carbs
- ☐ Graze; small, frequent meals (How many per day? _____)

Current level of exercise (Please check one that applies):

- ☐ None
- ☐ Light exercise (1-3 times per week, easy pace, stretching, walking, etc.)
- ☐ Moderate exercise (2-3 times per week, moderate pace, some weights, etc.)
- ☐ Heavy exercise: (3-4 times per week, vigorous pace, weights, fast running, etc.)

Health Information

Past or Present Health Conditions (Please check all that apply):

- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Strokes
- ☐ Heart Attack/Heart Disease
- ☐ High Blood Pressure
- ☐ Hormone Imbalance
- ☐ Thyroid Imbalance
- ☐ Anorexia/Bulimia
- ☐ Glaucoma
- ☐ Drug Addiction
- ☐ Currently pregnant or nursing
- ☐ Blood Clots
- ☐ Cancer
- ☐ Allergic to medication, if so, what

If you checked any of the above, please explain: _____
Have you ever been hospitalized, under medical care, or checked into rehab for alcohol or drug treatment?: ☐ Yes ☐ No
If you answered yes, please explain: _____
_____

Please list all medications you are currently taking, including doses and reasons for taking

Medication:	Dose:	How often:	Reason:

Current Symptoms Please check any symptoms you are now experiencing.

Weight:
- ☐ Inability to lose weight
- ☐ Food cravings
- ☐ Binge eating
- ☐ Nausea or vomiting
- ☐ Water retention

Digestive Symptoms:
- ☐ Stomach pains or cramping
- ☐ Constipation
- ☐ Diarrhea
- ☐ Reflux or heartburn
- ☐ Bloating
- ☐ Gas

Head and Ears:
- ☐ Migraines
- ☐ Headaches
- ☐ Wheezing

Sinus and Respiratory:
- ☐ Asthma
- ☐ Chest congestion
- ☐ Chronic cough
- ☐ Frequent sneezing

Emotional and Mental:
- ☐ Depression
- ☐ Anxiety

Energy:
- ☐ Fatigue
- ☐ Lethargy
- ☐ Restlessness
- ☐ Insomnia
- ☐ Hyperactivity

Other Symptoms:
- ☐ Irregular heartbeat
- ☐ Chest pains

Please list any symptoms you experience that were not previously mentioned: _____
_____
_____

What is most important to you in deciding to use our services? (Please check all that apply):
- ☐ Effectiveness “My results are my top priority.”
- ☐ Time “I want results quickly.”
- ☐ Service “I need extra support along the way.”
- ☐ Ease “I have a difficult time losing weight.”

_____ _____
Signature: **Date:**