Weight Management Program Intake Form

Name: _____ Date: _____

Intestinal Health

1. Do any of these apply to you:
   Sensitivity or allergy to any food, drugs or supplement(s)? If so, list them below:

Crohn's disease..... Y / N
Ulcerative Colitis..... Y / N
Irritable Bowel Syndrome ..... Y / N
Celiac Disease ..... Y / N
Stomach or Duodenal Ulcer .....Y / N
Diverticular Disease.....Y / N

2. Any surgery involving esophagus, stomach, gallbladder, small intestine, large intestine (colon-rectum)
   Y / N If so, describe:

Weight History

1. When did you first become overweight or become concerned about your weight? (your age then) _____(what year) ____
2. How did your weight gain start? Describe the circumstances:
3. What do you think is the cause of your weight problems?
4. Your present weight: _____ your weight goal: _____height: _____
5. What was your highest weight? (excluding pregnancy) _____ your age then ____ # of years ago:_____
6. What was your lowest weight? ____ your age then _____# of years ago:_____
7. Have you ever stayed the same weight for 10 years or more? Y / N
8. Have you attempted to lose weight before? Y / N Most lbs. lost:_____ How long it took:_____
9. Describe previous methods of weight loss (e.g. diets, pills, injections, hypnosis, acupuncture, programs) and describe your results:

10. Where and when are you most prone to overeating, or snacking when not hungry, if this applies?

11. What foods do you typically eat when snacking?

12. HOW MOTIVATED ARE YOU TO LOSE WEIGHT NOW?
    On the scale below, make a mark of where you stand.

< 1----------5----------10 >

Not very motivated VERY MOTIVATED!

13. Do you currently have any medical concerns not yet covered on these forms? Please list:

Exercise History

Do any of the following apply to you:

1. Your doctor has informed you that you have heart trouble or a heart condition of some kind **Y / N**
2. You frequently have pain in your chest or have had chest pain recently **Y / N**
3. You often feel faint or have spells of severe dizziness that are not caused by an inner ear condition **Y / N**
4. You have been informed that you have high blood pressure **Y / N**
5. You are over the age of 65 and are unaccustomed to vigorous exercise **Y / N**
6. Describe your present exercise routine as well as any significant: Physical Activity at Work, Recreational Activities and Sports Exercise/Activities:

All above statements on this patient intake form are accurate and true to the best of my knowledge.

Patient's Signature Date