Intake Form

Client's Name ___________________________ Age _________ Date of Birth ________________

Address ____

City ____ Zip Code ___________________

Telephone Number – Day _____________________ Evening or cell _______________________

Occupation _________________________________ Any physical activity at work? ___________

E-mail Address ____

Personal Physician ________________________________ Telephone Number _______________

Adult Weight History

Height ________ Weight__________ BMI (if known)___________

Minimum Wt. _______ Age _______ Maximum Wt. _______ Age _______

Age at onset of weight problems? ______

Previous weight loss methods?____

What is your reason for wanting to lose weight at this time?

____

Other than weight, what goals do you have for yourself in regards to your health and lifestyle?

____

Social Support System

Who do you live with?____

Are they supportive of your decision to lose weight and how do you think they will be supportive?____

Social History

Tobacco: Yes _______ No _______ How much per day? _________________________________

Alcohol: Yes _______ No _______ How much per day/week/month/year? _________________

Caffeine consumption: Yes _______ No _______ What? How often? _______________________

Recreational Drugs: Yes _______ No ________ What? How often? ________________________

Routinely exercise: Yes _______ No _______ What? How often? _________________________

Do you walk a mile or more daily? ____

Medical History

Do you have any of the following? Please circle all that apply and provide information for circles under Group A in the lines below.

GROUP A (require physician monitoring)

DIABETES

HEART FAILURE or ANGINA
TAKING COUMADIN

KIDNEY FAILURE

LIVER FAILURE OR CIRRHOSIS
HIGH BLOOD PRESSURE
GALLSTONES

GROUP B (OK if Dr. consent)

Anemia/other blood disease

Arthritis (bone/joint disease)
Reflux

Constipation or diarrhea

Gout
Seizures/convulsions

Sleep Apnea on CPAP Low Thyroid
Food Allergies
Cancer
Other Current Medical Conditions

____

____

____

Psychiatric (please circle & continue current treatment): depression, anxiety attacks, bulimia, anorexia nervosa, substance/alcohol addiction, ongoing counseling:

____

Recent hospitalization and/or surgery (include dates):_________________________________

____

Currently pregnant? _________LMP: _________

How many past pregnancies? _________ Deliveries? _________Any Complications? _________

Current Medications

All Current Medications You Take:

____

____

Diuretics?____

Insulin?____