

Patient Information Sheet

Today's Date:

General Information

Last Name: First Name:

Date of Birth: Current Age Occupation

Marital Status: S M D W Gender: Male Female

Address: Home Phone:

City: Work Phone:

State: Cell Phone:

Zip Code: Email Address::

Are you a former client? Y N If yes, which location?

Date of last visit?

Emergency Contact Information

Name: Phone:

Relationship:

Referral Source

How did you hear about us?

- | | | |
|---|--|------------------------------------|
| <input type="checkbox"/> Friend (Name_____) | <input type="checkbox"/> Internet Search | <input type="checkbox"/> Sales Rep |
| <input type="checkbox"/> Co-worker (Name_____) | <input type="checkbox"/> Mail Invitation | <input type="checkbox"/> Physician |
| <input type="checkbox"/> Radio | <input type="checkbox"/> Phone | <input type="checkbox"/> Email |
| <input type="checkbox"/> Groupon Ad / Internet Ad | | |

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Medical History

Please indicate if you (self) or any blood relative has or has had any of the following conditions:

Relative	Self	
		Abdominal Pain
		Accident (major)
		Alcoholism / Drug Addiction
		Allergy (any)
		Anemia
		Anorexia
		Anxiety
		Arthritis
		Asthma
		Bad Taste in Mouth
		Back Pain
		Excessive Belching or Bur
		Bladder Problems
		Bleeding
		Blood / Stones / Pus in U
		Blood Transfusion
		Bulimia
		Chest Pain
		Cancer / Tumor
		Constipation
		Coughing
		Depression
		Diabetes
		Dry Skin
		Eczema
		Epilepsy / Seizures
		Fainting / Dizziness
		Gall Stones
		Gland Problems
		Gastritis
		Goiter
		Gout
		Hair Loss
		Headache / Migraine
		Heartburn
		Heart Disease
		Tuberculosis
		Vision Problems

Relative	Self	
		Hemorrhoids
		Hepatitis
		High Blood Pressure
		High Cholesterol
		HIV / Aids
		Hot or Cold Flashes
		Increased Urination
		Irritable Bowel Syndrome
		Joint or Muscle Aches
		Jaundice
		Kidney Disease
		Liver Disease
		Lung Disease
		Memory Lapses
		Mental Illness
		Nail or Cuticle Problems
		Nausea or Vomiting
		Neurological Disorder
		Osteopenia / Osteoporosis
		Pain or Burning with Urination
		Palpitations
		Paralysis
		Pneumonia
		Poisoning / Medication Overdose
		Recent Change in Bowel Habits
		Recurrent Colds
		Ringing or Buzzing in Ears
		Rheumatic Fever
		Sexually Transmitted Disease
		Sleep Problems
		Shortness of Breath
		Sinus Trouble
		Stomach / Intestine / Colon Disorder
		Swollen Legs / Ankles / Feet
		Stroke
		Thyroid Disease
		Unusual Thirst
		Varicose Veins

Other Medical Problems:

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Surgical History & Hospitalizations

Surgical History:

Date	Operation

Hospitalizations:

Date	Illness / Injury

Family / Social History

Father Deceased Yes No Age: Cause of Death:

Mother Deceased Yes No Age: Cause of Death:

Do you smoke or use any tobacco products? Yes No

Do you use any illegal or street drugs? Yes No

How many hours of sleep do you get on an average night?

Do you work a night shift? Yes No

If so, how many nights per week?

Medications & Allergies

Medications *(list current medications)*

Name	Dose

Allergy History *(list any allergy you have had)*

Name

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Medications & Allergies (continued)

Vitamins, Minerals & Supplements *(list current supplements)*

Name

Diet & Activities

What is the lowest weight as an adult that you maintained?

Have you ever had an eating disorder?

Yes No

What medications or supplements have you taken in the past in an attempt to lose weight? (list all)

What other diets have you tried in the past?

Select your activity level? Inactive Light Moderate Heavy Vigorous

What types of exercise do you do and how often?

Why are you having difficulty managing your weight?

Overeating

Slow Metabolism

Eating wrong foods

Stress Eating

Not exercising enough

Other:

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Diet & Activities (continued)

What are your problem meals?

- Breakfast Morning snack Brunch Afternoon snack
 Lunch Evening snack

What foods do you eat too much of?

- Carbohydrates Protein Sweets Fats Alcohol

How much did you weight at age 18?

Were you overweight as a child?

- Yes No

Do you feel out of control while eating?

- Yes No

If so, which foods?

If you have lost weight, and then regained, please indicate the 3 most important reasons for the weight gain:

- | | | |
|---|--|--|
| <input type="checkbox"/> less exercise | <input type="checkbox"/> overeating at meals | <input type="checkbox"/> stress |
| <input type="checkbox"/> infrequent clinical visits | <input type="checkbox"/> socializing | <input type="checkbox"/> stopped weight checks |
| <input type="checkbox"/> lack of support | <input type="checkbox"/> depression | <input type="checkbox"/> lack of planning |
| <input type="checkbox"/> other <input style="width: 120px; height: 20px;" type="text"/> | | |

What do you believe will be of the most help to assist you in losing weight?

Do you follow a special diet?

- No Kosher
 Low fat Low Sodium
 Diabetic Vegetarian
 Other:

Which meals do you regularly eat?

- Breakfast Morning snack
 Brunch Afternoon snack
 Lunch Evening snack
 Dinner

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Diet & Activities (continued)

Do you usually eat out or order food in? Yes No
How often? Daily Weekly Monthly Other

How is your food usually prepared? Baked Broiled
 (pick all that apply) Steamed Poached
 Boiled Fried

What beverages do you drink daily and how much?

Water 8oz glasses per day
 Coffee cups per day
 Tea cups per day
 Soda 12oz glasses per day
 Beer 12oz glasses per day
 Wine 6oz glasses per day
 Mixed Drinks 6oz glasses per day
 Other 8 oz glasses per day
 Specify: