New Patient Questionnaire (Health Care Analysis)

Today's Date: _____

Patient Information:

First Name:	**Last Name:**	**Email:**	
_____	_____	_____	
Address:		**City:**	**State:** **Zip Code:**
_____		_____	_____ _____
Home Phone:	**Work Phone:**	**Cell Phone:**	**Date of Birth:**
_____	_____	_____	_____
Height:	**Weight:**	**Marital Status:**	**Gender:**
_____	_____	☐ S ☐ M ☐ D ☐ W	☐ M ☐ F
How did you hear about us?:		**If referred by someone, who?:**	
_____		_____	

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

How many pounds would you like to lose?: _____

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

_____

What was your **highest** weight in the past 3 years? _____ Your **lowest** weight in the past 3 years? _____

Who has encouraged you to lose weight?: _____

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?: _____

Have you been advised by your physician to lose weight?: ☐ Yes ☐ No If Yes, who is your doctor? _____

Current level of exercise (Please check one):

- ☐ 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.)

What has been the hardest part about managing your weight? _____

_____

What do you believe will be most helpful to assist you in losing weight? _____

_____

How would reaching your ideal weight change your life? _____

_____

How do you feel mostly throughout the day? ☐ Tired/Fatigued ☐ Energetic/Alert

How do you feel overall on a daily basis?

Unwell 1 2 3 4 5 Very well

How often do you find yourself sad or depressed for no definitive reason?

Never 1 2 3 4 5 All the time

Please rate your overall health:

Not healthy 1 2 3 4 5 Very healthy

Your level of interest in losing weight is:

Not interested 1 2 3 4 5 Very interested

Are you ready to make significant lifestyle changes?

Not ready 1 2 3 4 5 Very ready

How much support can your friends and/or family provide?

No support 1 2 3 4 5 Lots of support

How confident are you that you can reach your weight loss goal?

Not confident 1 2 3 4 5 Very confident

How committed are you to making this change in your life right now?

Not committed 1 2 3 4 5 Nothing can stop me!

Do you suffer/Have you suffered from any of the following medical conditions? (Check all that apply)

☐ Heart Disease ☐ Diabetes ☐ High Cholesterol ☐ High Blood Pressure ☐ Stroke

☐ Cancer ☐ Obesity ☐ Thyroid Disease ☐ Arthritis ☐ None apply

☐ Other health issues/concerns: _____

Check all that apply:

- ☐ I often have cravings for sugary or other types of food throughout the day
- ☐ I struggle with eating healthy and/or regularly throughout the day
- ☐ I lack protein in my diet from meats, legumes, and/or other sources

Do you eat because of emotions?: ☐ Yes ☐ No If yes, please explain: _____

_____

Do you have any eating habits that you feel particularly ashamed of? _____

Check all the following that you would be willing to do:

- ☐ Commit to one visit a week
- ☐ Weigh your daily protein portions
- ☐ Eat sitting down
- ☐ Weigh yourself daily
- ☐ Complete a daily food diary
- ☐ Review your top reasons for losing weight on a daily basis

Rate how important each of the following advantages of losing weight are to you:

	Not Important	Somewhat Important	Important	Very important
I won't feel so self-conscious.	☐	☐	☐	☐
I'll live longer.	☐	☐	☐	☐
I'll have more energy.	☐	☐	☐	☐
I'll like myself more.	☐	☐	☐	☐
I'll feel more in control.	☐	☐	☐	☐
I'll be more attractive to others.	☐	☐	☐	☐
I'll do more things I'd like to do.	☐	☐	☐	☐
I'll enjoy sexual intimacy more.	☐	☐	☐	☐
I'll feel more outgoing.	☐	☐	☐	☐
I'll be less self-critical.	☐	☐	☐	☐
I'll get more compliments.	☐	☐	☐	☐
I'll be able to wear nicer clothes.	☐	☐	☐	☐
I'll enjoy clothes shopping more.	☐	☐	☐	☐

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."

I understand that my patient file will be kept completely confidential unless I give written permission for my information to be released.

_____ _____

Signature: **Date:**