

New Patient Questionnaire (Health Care Analysis)



Today's Date: _____

Patient Information:

Name: _____ Home Phone: _____
Secondary Phone: _____ E-mail: _____
Address: _____ City: _____ State: _____ Zip: _____
Age: _____ DOB: __/__/____ Marital Status: S M W D Number of Children: _____
Employer: _____ Occupation: _____
Employer Address: _____ City: _____ State: _____ Zip: _____
Insurance Company: _____ SSN: _____ - _____ - _____
Driver's License #: _____ Exp: __/__/____
Emergency Contact: _____ Relationship: _____
Best Number: _____
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

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):

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

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):

- | | |
|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Imbalance |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Anorexia |
| <input type="checkbox"/> Strokes | <input type="checkbox"/> Bulimia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Currently pregnant or nursing |
| <input type="checkbox"/> Hormone Imbalance | <input type="checkbox"/> Allergic to sulfur, food or medication |

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:	Prescribing M.D.

Food and Chemical Sensitivity

Please complete the following survey using the key below

- = No symptoms (0 points)
- = Mild symptoms (1 point)
- = Moderate symptoms (2 points)
- = Severe symptoms (3 points)

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
- Earaches
- Wheezing
- Ear infection

- Ringing in ears

Eyes and Throat:

- Itchy eyes
- Watery eyes
- Sore throat
- Persistent canker sores

Sinus and Respiratory:

- Stuffy or runny nose
- Asthma
- Chest congestion
- Chronic cough
- Frequent sneezing

Skin Disorders:

- Dermatitis
- Excessive sweating
- Rashes
- Hives
- Eczema

Emotional and Mental:

- Depression
- Anxiety
- Mood swings
- Irritability
- Poor concentration

Other Symptoms:

- Joint pain
- Arthritis
- Irregular heartbeat
- Chest pains
- Muscle aches

Energy:

- Fatigue
- Lethargy
- Restlessness
- Insomnia
- Hyperactivity

OFFICE USE ONLY
Total Points: _____

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:

Notes:
