New Patient Weight Loss Intake Form

Basic Patient Information

Name:	Date:	
Street Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Email Address:		
Sex: M F Birth Gender: M F	Birth date:	Height: Weight:
Race (ie. White, Asian, African American):	Hispanic or Latino: □ Yes □ No	
Marital Status: □ Single □ Married □ Widowed □ Separated □ Divorced		
Occupation:		
How did you hear about us?		
Primary Care Physician:	Phone:	
Emergency Contact:	Phone:	Relationship:

Health and Wellness History

Has your doctor advised you to lose weight?		
Do you have any dietary restrictions? Please explain:	□ Yes	□ No
How often do you exercise?	What type of exercise?	
Do you feel stressed? Please explain:	□ Yes	□ No
Check ALL that apply to you: □ Pregnant □ Might Be Pregnant □ Breast Feeding □ Currently Undergoing Chemotherapy		

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

What changed that caused the weight gain (if anything)?_____

What's the main reason you are seeking treatment at this time? _____

What are your goals about weight control and management? _____

What do you consider to be your ideal weight? _____

When was the last time you were at your ideal weight? _____

How much weight do you want to lose? _____

How many times a year do you diet? _____

What is the hardest part about managing your weight? _____

What have you tried in the past that has failed? _____

Please check all previous programs that you have tried in order to lose weight. Indicate dates and length of and any current medications:

Program	Date	Medication	Dose/Freq.
Weight Watchers			
Liquid Diets			
Keto Diet			
Diet Pills (Phen-Fen)			
Nutrisystem/Jenny Craig			
Surgery			

Have you maintained weight loss for up to a year with any of these programs?_____
What did NOT work for you about these programs?_____
What has been your lowest _____ and highest _____ weight as an adult?
What's more important inches lost or pounds? _____
What's more important, fast or permanent? _____
How fast do you want to be slim, trim and fit? _____
What would stop you from a weight loss program? _____

Do you binge eat?	□ Yes	□ No
Do you suffer from uncontrollable cravings?	□ Yes	□ No
Do you feel that food controls you?	□ Yes	□ No
Do you eat because of your emotions?	□ Yes	□ No
Do you eat between meals?	□ Yes	□ No
What do you choose to eat between meals?		
Do you feel that your eating behaviors are normal?	□ Yes	□ No
Briefly describe your daily eating behaviors:		
Does your family support your weight loss efforts?	□ Yes	□ No
Can you remember being at your ideal weight?	□ Yes	□ No
What do you remember most about it?		
Commitment to weight loss: (please rate): (low) 1 2 3 4 5 6 7 8 9 10 (high)		

CENTER FOR WELLBEING®

What is the most important element in deciding to use our services?
(Circle only ONE of the four answers):

EFFECTIVENESS:	"My results are my top priority."
TIME:	"I want results quickly."
SERVICE:	"I need extra support along the way."
AFFORDABILITY:	"I need this to be affordable."

Check the following conditions you would like help with or more information on:

□ Weight Loss	□ Thyroid	□ Knee Arthritis	□ Memory & Mood
□ Hormone Balancing	□ Immune Boosting	□ Insomnia	□ Pain Relief
□ Neuropathy	□ Joint Pain	□ Quitting Smoking	□ Stress Relief
□ Fatigue	□ General Wellness	□ Diabetic Educ.	□ Fitness

List **ALL** medications & supplements you take (prescription & over the counter)

Drug Name:	Dosage:	How long have you taken & for what conditions?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all ***known DRUG and FOOD allergies***:

Drug Name/Food Name:	Reaction:
_____	_____
_____	_____
_____	_____

Check **ALL medical conditions** that you may have had or currently have now:

__ADD/ADHD
__Alcoholism
__Allergy
__Alzheimer's
__Anemia
__Appendicitis
__Asthma
__Arthritis
__Cancer
__Celiac Disease
__Chronic Fatigue
__Migraine
__Depression
__Diabetes
__Eczema
__Emphysema
__Epilepsy/seizures
__Fibromyalgia
__Gall Bladder
__Goiter
__Gout
__Heart Attack
__Heart Disease
__Vertigo/Dizziness
__Hepatitis
__High Blood Pressure
__High Cholesterol
__High Blood Sugar
__HIV/AIDS
__Irritable Bowel
__Kidney Infect./stones
__Low Blood Pressure
__Low Blood Sugar
__Lyme Disease
__Lupus
__Miscarriage
__Multiple Sclerosis
__Parkinson's
__Pneumonia
__Raynaud's
__Rheumatoid Arthritis
__Ringing in ears
__Sinus Infection
__Stroke
__Thyroid Problems
__Ulcers

Other: _____

Please list all previous surgeries & dates:

_____

_____

Alcohol use? Yes / No Amount _____ Daily / Weekly / Socially

Tobacco use? Yes / Never / Former Smoker PPD _____ How many years? _____

AUTHORIZATION & NOTICE OF PRIVACY PRACTICES

I understand that my private healthcare information is protected under HIPPAA Privacy Regulations.

*May we leave a message for you on your answering device? Yes_____ No_____

I fully understand that my signature is consent and authorization to be examined by the Center for Wellbeing medical team.

I understand that my entire patient history will remain completely confidential and will not be released without express written consent from me.

Patient Signature _____ Date _____

CANCELLATION AND NO-SHOW POLICY

We understand that situations arise in which you must cancel your scheduled appointment. It is therefore requested that if you must cancel your appointment you provide a 24 hour notice. Appointments which are cancelled within less than 24 hour notice may be subject to pay the full balance owed at the time of cancellation. Cancellation and no show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that unavoidable circumstances may cause you to cancel with less than a 24-hour notice, fees may be waived upon management approval.

Our practice firmly believes that good physician/patient relationships are based upon understanding and good communication. Questions about cancellation and no show fees can be directed to the front desk at (603) 380-9159.

Please sign that you have read, understand and agree to this cancellation and no-show policy.

_____

Patient Name (Please Print) Date

_____

Signature of Patient Date