



## 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> 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:	<input type="checkbox"/> Yes <input type="checkbox"/> No
How often do you exercise?	What type of exercise?
Do you feel stressed? Please explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Check ALL that apply to you: <input type="checkbox"/> Pregnant <input type="checkbox"/> Might Be Pregnant <input type="checkbox"/> Breast Feeding <input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you suffer from uncontrollable cravings?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel that food controls you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you eat because of your emotions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you eat between meals?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What do you choose to eat between meals?		
Do you feel that your eating behaviors are normal?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Briefly describe your daily eating behaviors:		
Does your family support your weight loss efforts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Can you remember being at your ideal weight?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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)		



***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:***

<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Knee Arthritis	<input type="checkbox"/> Memory & Mood
<input type="checkbox"/> Hormone Balancing	<input type="checkbox"/> Immune Boosting	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Pain Relief
<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Quitting Smoking	<input type="checkbox"/> Stress Relief
<input type="checkbox"/> Fatigue	<input type="checkbox"/> General Wellness	<input type="checkbox"/> Diabetic Educ.	<input type="checkbox"/> 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:

- |                                          |                                            |                                                |                                               |
|------------------------------------------|--------------------------------------------|------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> ADD/ADHD        | <input type="checkbox"/> Depression        | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Miscarriage          |
| <input type="checkbox"/> Alcoholism      | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Multiple Sclerosis   |
| <input type="checkbox"/> Allergy         | <input type="checkbox"/> Eczema            | <input type="checkbox"/> High Cholesterol      | <input type="checkbox"/> Parkinson's          |
| <input type="checkbox"/> Alzheimer's     | <input type="checkbox"/> Emphysema         | <input type="checkbox"/> High Blood Sugar      | <input type="checkbox"/> Pneumonia            |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> Raynaud's            |
| <input type="checkbox"/> Appendicitis    | <input type="checkbox"/> Fibromyalgia      | <input type="checkbox"/> Irritable Bowel       | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Gall Bladder      | <input type="checkbox"/> Kidney Infect./stones | <input type="checkbox"/> Ringing in ears      |
| <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Goiter            | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Sinus Infection      |
| <input type="checkbox"/> Cancer          | <input type="checkbox"/> Gout              | <input type="checkbox"/> Low Blood Sugar       | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Celiac Disease  | <input type="checkbox"/> Heart Attack      | <input type="checkbox"/> Lyme Disease          | <input type="checkbox"/> Thyroid Problems     |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Heart Disease     | <input type="checkbox"/> Lupus                 | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Migraine        | <input type="checkbox"/> Vertigo/Dizziness |                                                |                                               |

**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 HIPAA 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



**Authorization to Disclose Medical Records and Health Information**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

**Records Release To:**

Provider/Clinic/Organization: \_\_\_\_\_ CENTER FOR WELLBEING \_\_\_\_\_

Bedford Office:

**Address:** 18 Constitution Drive Suite 2, Bedford, NH 03110 **Phone:** 603-472-6192 **Fax:** 603-472-6196

Portsmouth Office:

**Address:** 3201 Lafayette Road, Portsmouth, NH 03801 **Phone:** 603-380-9159 **Fax:** 603-427-8290

**I hereby authorize the release of my medical records to the designated provider listed above.**

**Please Initial**

\_\_\_\_\_ Complete Medical Record

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_