NEWTOWN
HEALTH CENTER

Application for Weight Loss Program

Patient Information

Date: -_____

Name:_____ I prefer to be called:_____

Circle: Male Female Minor Single Married Widowed Separated Divorced

Address:_____

City:_____ State: _____ Zip Code: _____

Home Phone: ( ) _____ Cell Phone: ( )_____

Best time to contact me is: _____AM or PM on my HOME CELL

Date of birth:_____ Age:_____ Social Security # _____-_____-_____

Whom may we thank for referring you? _____

If you were not referred, how did you hear about us? _____

Person to contact in case of an emergency: _____Phone ( )_____

Name of local primary physician: _____May we contact them?_____

Email Address: _____May we contact you via email?_____

** We will not sell or distribute your email address to any 3rd parties. Emails are used for patient communication regarding our newsletter and special events/announcements**

Responsible Party (Other than self)

Name: _____ Relationship to Patient: _____

Address: _____

City: _____State: _____ Zip code: _____

Home Phone: ( )_____ Cell Phone ( )_____

Health History

____Acid Reflux	____Bulimia	____Dizziness	____High Cholesterol	____Numbness
____Allergies	____Cancer	____Elbow/wrist pain	____Immune	Tingling in legs/
____Anemia	____Chronic Infections	____Fatigue/Tiredness	____Kidney Disease	feet/arm/hand
____Anorexia	____Concussion	____Headaches	____Knee Pain	____Shoulder/
____Arthritis	____Depression	____Heart Disease	____Leg/Hip Pain	arm pain
____Asthma	____Diabetes	____Hepatitis	____Liver/Gallbladder	____Sinus
____Bladder	____Difficulty Sleeping	____Hernia	____Low back Pain	____Skin
____Bowel	____Digestion	____High Blood Pressure	____Neck Pain	____Stroke
____ COPD	____Diverticulitis	____Thyroid	____Weight Problems	____Vision

Weight Loss Questionnaire

1. Is there a reason you are seeking treatment at this time?

_____

2. What are your goals about weight control and management?

_____

3. Your level of interest in losing weight is:

1 2 3 4 5

Not Interested Very Interested

4. Are you ready for lifestyle changes to be a part of your weight control program?

1 2 3 4 5

Not Interested Very Interested

5. How much support can your family provide?

1 2 3 4 5

Not Interested Very Interested

6. How much support can your friends provide?

1 2 3 4 5

Not Interested Very Interested

7. What is the hardest part of managing your weight?

_____

8. What do you believe will be the most helpful in helping you to lose weight?

_____

9. What has been your lowest and highest weight as an adult?

Lowest:_____ Highest:_____

10. At what age did you start trying to lose weight?_____

11. Please check all previous programs that you have tried in order to lose weight. Please indicate dates and lengths of participation.

PROGRAM	DATE	DURATION (MONTHS)	WEIGHT LOST
Weight Watchers			
Overeaters Anonymous			
Liquid Diets			
Diet Pills (Meridia, Xenical)			
Diet Pills(Phen-Fen,Redux)			
Nutrisystem/JennyCraig			
OTC Diet Pills			
Registered Dietician			
Weight loss Surgery			

12. Have you maintained any weight loss up to 1 year on any of these programs? ____yes ____no

13. What did you learn from these programs regarding your weight?

_____

_____

14. What did not work about these programs?

_____

_____

15. How important is it that you lose weight at this time?

a. Not b. Not Very c. Somewhat d. Very important e. Imperative

16. Have you tried to lose weight before? _____yes _____no

17. What factors led to your success?

a. Encouragement from others b. Determination c. Goal – Event with old friend

18. How does being overweight affect you?

a. Limits exercise b. Can't wear my clothes c. Tired all the time
d. My knees hurt e. My back hurts f. I feel ugly

19. What has made weight loss difficult?

a. Travel b. Holidays c. Weekends d. Parties
e. Hunger f. Cost of care g. Peer Pressure h. Family

20. What is hard about managing your weight?

a. No will power b. I've always been overweight c. No exercise d. Schedule too busy
e. Hungry all the time f. I don't like vegetables g. I'm a meat & potatoes person
h. I'm addicted to sugar i. I like beer

21. Do you follow a special diet?

a. No b. Diabetic c. Low Sodium d. Low fat
e. Kosher f. Vegetarian g. None h. Other: _____

22. When do you snack?

a. Morning b. Afternoon c. Evening d. Late Night e. Throughout the day

23. What meals do you eat regularly?

a. Breakfast b. Brunch c. Lunch d. Dinner

24 . What are your favorite snack foods?

_____

_____

25. Do you eat out or order food in? _____yes _____no

26. How is your food usually prepared?

a. Baked b. Boiled c. Broiled d. Fried e. Poached f. Steamed g. Other:_____

27. How many times per day do you have the following items?

ITEM	TIMES PER DAY
Starch (bread, cereal, pasta, rice, noodles, potatoes)	
Fruit	
Vegetables	
Dairy (milk, yogurt, cheese)	
Meat (fish, poultry, eggs)	
Fat (butter, margarine, mayonnaise, oil, salad dressing, sour cream, cream cheese)	
Sweets (candy, cake, regular soda, juice)	

28. What beverages do you drink daily and how much?

DRINK	TIMES OR 8 OZ GLASSES PER DAY
Water	
Coffee	
Tea	
Soda	
Alcohol	
Other	

29. Would you like to change your eating habits? _____yes _____no

30. What habits would you like to begin to change?

_____

_____

31. Is your decision to lose weight your own or for someone else?

a. Mine b. My wife c. My husband d. My parents e. My friends

32. Is your family supportive? _____ yes _____no

33. What can't you do now that you would like to do if you weighed less?

a. Ride a bike b. Go Bowling c. Play golf d. Go for walks
e. Play with my children/grandchildren f. Get into my old clothes

34.What would you like to get out of this visit regarding your weight?

a. A diet b. Accountability c. Understanding about what makes me gain weight d. Medication
e. Evaluation of what is making me gain weight