



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, newsletters and special events/announcements**

Appointment Reminders: TEXT ONLY CALL ONLY BOTH TEXT & CALL

Responsible Party (Other than self)

Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: () _____ Cell Phone () _____

Health History

- | | | | | |
|--------------------------------------|--|--|--|--|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Bulimia | <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Elbow/wrist pain | <input type="checkbox"/> Immune | <input type="checkbox"/> Tingling in legs/ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronic Infections | <input type="checkbox"/> Fatigue/Tiredness | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> feet/arm/hand |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Concussion | <input type="checkbox"/> Headaches | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Shoulder/ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Leg/Hip Pain | <input type="checkbox"/> arm pain |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Liver/Gallbladder | <input type="checkbox"/> Sinus |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Hernia | <input type="checkbox"/> Low back Pain | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Bowel | <input type="checkbox"/> Digestion | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Weight Problems | <input type="checkbox"/> Vision |

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