DESERT EDGE MEDICAL

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MEDICAL WEIGHT LOSS PROGRAM INTAKE FORM

PATIENT INFORMATION

Patient Name: _____ **Sex:** ☐ M ☐ F ☐ Other

Mailing Address: _____ **Date of Birth:** _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Occupation: _____

EMERGENCY CONTACT

Name: _____ **Phone #:** _____ **Relationship:** _____

Name: _____ **Phone #:** _____ **Relationship:** _____

How did you hear about us? _____

Are you under the care of a qualified healthcare professional? Please list whom:

_____

As detailed in the Consent portion, it is highly recommended that you are under the care of a qualified healthcare professional, who has verified that it is safe for you to exercise and be on a weight loss program and is monitoring medications and any health concerns that you list here (besides your weight issues- that's what we're covering). If you are on medications (particularly for high blood pressure, heart issues, or diabetes), you will need these to be monitored during and after the program as your need for them may change.

I acknowledge the statement above. Sign: _____

MEDICAL HISTORY

Please list any medical conditions a medical provider has diagnosed you with in the past (such as high blood pressure, diabetes, arthritis, etc...):

What medications, supplements and over the counter items do you take regularly or are currently prescribed?

Any past surgeries and hospitalizations?

Please describe your family history in terms of heart disease, diabetes, obesity, high cholesterol, high blood pressure, and cancer:

PERSONAL HISTORY

What are your main interests and hobbies?

What is your line of work or study?

Do you exercise regularly? Please detail.

What kind of other movement or activities do you enjoy?

Do you have problems falling or staying asleep?

How many hours do you sleep?

Do you wake up refreshed?

How is your energy?

Does your energy level affect your daily activities?

How would describe your mood, generally:

Does your mood affect your life or daily activities?

How would you describe your stress level?

What are your sources of stress?

How do you manage stress?

Do you have people close to you who support you?

DIET AND LIFESTYLE

Do you regularly drink alcoholic beverages? ☐ Yes ☐ No

If yes, how many per week? _____

Do you smoke tobacco? ☐ Yes ☐ No Do you use recreational drugs? ☐ Yes ☐ No

How is your appetite?

Snack Habits:

What: _____

How much: _____

When: _____

Typical Breakfast:

What: _____

How much: _____

When: _____

Typical Lunch:

What: _____

How much: _____

When: _____

Typical Dinner:

What: _____

How much: _____

When: _____

How often do you eat out? _____

What restauraunts do you frequent? _____

How often do you eat “fast foods”? _____

Food allergies? _____

Food dislikes? _____

Food cravings? _____

Do you eat because of emotions (explain)? _____

Do you drink coffee or tea? If Yes, how much daily? _____

Do you drink pop / soft drinks? If yes, how much? _____

Do you use sugar substitutes? _____

What are your worst food habits? _____

How much fluids do you normally drink? Approximate in ounces. _____

Please list all types of beverages you regularly drink. _____

_____

Please list any food allergies, intolerances, or foods you avoid and the reason. _____

_____

_____

What past struggles and difficulties have you experienced in terms of food and dieting?

_____

_____

_____

What diet and exercise programs, protocols, plans or approaches have you tried in the past?

_____

_____

_____

What types of diet and exercise approaches have worked for you in the past?

What types of diet and exercise approaches have NOT worked at all for you in the past?

When did you first become overweight?

How did your weight gain start? Describe any circumstances:

What do you think is the cause of your weight problem?

What was your highest weight? (excluding pregnancy)

What was your lowest weight?

Have you ever stayed the same weight for 10 years or more?

How MOTIVATED are you to lose weight?

Is there anything else you would like to tell us?

Please check the factors you feel have contributed to your current weight (check all that apply):

- ☐ Slow metabolism
- ☐ Family history of obesity
- ☐ Comfort food dependency
- ☐ Lack of exercise
- ☐ Binge eating
- ☐ Late night snacking
- ☐ History of trauma
- ☐ History of grief and loss
- ☐ Medication related weight gain
- ☐ Significant restrictive eating behaviors like anorexia

HEALTH HISTORY

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE:

A: No, never
B. Yes, currently
C: Not currently, but within the last year
D: Not currently, and longer than a year ago

A	B	C	D	
☐	☐	☐	☐	Fatigue
☐	☐	☐	☐	Unexplained weight loss or gain
☐	☐	☐	☐	Change in appetite
☐	☐	☐	☐	Depressive symptoms
☐	☐	☐	☐	Anxiety
☐	☐	☐	☐	Mood swings
☐	☐	☐	☐	Nervousness
☐	☐	☐	☐	Addictive dependency
☐	☐	☐	☐	Disordered Eating
☐	☐	☐	☐	Pattern/Tendency
☐	☐	☐	☐	Tension
☐	☐	☐	☐	Lack of mental focus
☐	☐	☐	☐	Thyroid problems
☐	☐	☐	☐	Diabetes
☐	☐	☐	☐	Blood sugar irregularities
☐	☐	☐	☐	Excessive thirst or hunger
☐	☐	☐	☐	Sugar cravings
☐	☐	☐	☐	Abnormal hair growth
☐	☐	☐	☐	Excessive perspiration

A	B	C	D	
☐	☐	☐	☐	Feeling excessively hot or cold
☐	☐	☐	☐	Headache
☐	☐	☐	☐	Lightheadednes
☐	☐	☐	☐	Joint pain or stiffness
☐	☐	☐	☐	Muscle weakness or soreness
☐	☐	☐	☐	High blood pressure
☐	☐	☐	☐	Heart murmur/palpitations
☐	☐	☐	☐	Cold or pale extremities
☐	☐	☐	☐	Asthma
☐	☐	☐	☐	Short of breath
☐	☐	☐	☐	Heartburn
☐	☐	☐	☐	Abdominal discomfort after eating
☐	☐	☐	☐	Nausea
☐	☐	☐	☐	Abdominal bloating
☐	☐	☐	☐	Belching/gas
☐	☐	☐	☐	Constipation
☐	☐	☐	☐	Diarrhea
☐	☐	☐	☐	Daily bowel movements