Weight Management Intake Form

Demographics:

Name: _____ DOB: _____

Phone: _____ Email: _____

Preferred method of contact: _____

Weight History:

What is your purpose for seeking weight management /treatment? _____

_____

How long has weight been a concern? _____

What weight loss strategies/ methods have you tried in the past?_____

_____

Weight: Current: _____ Goal _____

Worst food habit is: _____

_____

Are you a stress eater? _____ Night eater? _____

Medical History:

Primary Care Physician: _____

Date of last complete physical exam: _____ Was it: ___ Normal ___Abnormal ___ Other

List tests/ labs/ Xrays you have had in the last year: _____

_____

List hospitalizations/ surgeries (and date): _____

_____

_____

Current exercise Routine: Daily / weekly / Occasionally _____

_____

_____

Targeted Past Medical History (please confirm what you may have already related to us)

	Do you have / had	Any Family members with this problem
Thyroid cancer/ disease		
Diabetes (Insulin/ Diet controlled)		
Diabetes Eye Disease		
Pancreas: inflammation / cancer		
Gall Stones		
Stomach/ gut problems		
Eating disorder		
Kidney disease/ dialysis		

Signature_____ Date: _____