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?

____

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? Y N

If yes, how many per week? ________________

Do you smoke tobacco? Y N

Do you use recreational drugs? Y N

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 restaurants 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? Y N If Yes, how much daily?

____

Do you drink pop / soft drinks? Y N If yes, how much? ______________________________

Do you use sugar substitutes? ____

What are your worst food habits? ____

How much fluids do you normally drink? Please 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?

____
____
____
____

And what hasn't worked for you at all?

____
____
____
____

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?

____

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____
____

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 list 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	

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Please answer the following questions to the best of your knowledge:

Health History *

	No, never	Yes, currently	Not currently, but within the last year	Not currently and longer than 1 year ago
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	◌	◌	◌	◌

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Excessive perspiration	◌	◌	◌	◌
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	◌	◌	◌	◌

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