NEW PATIENT  UPDATE DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEIGHT: \_\_\_\_’\_\_\_\_” WEIGHT: \_\_\_\_\_\_\_\_\_ LBS.  M  F

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MIDDLE

FIRST

LAST

MAILING ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_\_\_

HOME PHONE: (\_\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_ CELL PHONE: (\_\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ E-MAIL ADDRESS: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_.COM](mailto:____________________@__________.COM)

EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_\_\_

HOW DID YOU HEAR ABOUT OUR WEIGHT LOSS PROGRAM? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST MEDICAL HISTORY**, PLEASE CHECK YES OR NO **FAMILY HISTORY**, PLEASE CHECK YES OR NO

YES NO MEDICATIONS

YES NO RELATIONSHIP

|  |  |  |  |
| --- | --- | --- | --- |
| HYPERTENSION |  |  |  |
| HYPERLIPIDEMIA |  |  |  |
| HYPOTHYROIDISM |  |  |  |
| DIABETES MELLITUS |  |  |  |
| INSULIN RESISTANCE |  |  |  |
| CARDIAC STRESS |  |  |  |
| ASTHMA |  |  |  |
| DEPRESSION |  |  |  |
| GASTROINTESTINAL |  |  |  |
| KIDNEY DISEASE |  |  |  |
| ALCOHOLISM |  |  |  |
| DRUG ABUSE |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| HYPERTENSION |  |  |  |
| HYPERLIPIDEMIA |  |  |  |
| HYPOTHYROIDISM |  |  |  |
| DIABETES MELLITUS |  |  |  |
| CARDIAC STRESS |  |  |  |
| ASTHMA |  |  |  |
| DEPRESSION |  |  |  |
| GASTROINTESTINAL |  |  |  |
| KIDNEY DISEASE |  |  |  |
| ALCOHOLISM |  |  |  |
| DRUG ABUSE |  |  |  |

LIST OF CURRENT MEDICATIONS (IF NOT LISITED ABOVE): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PAST SURGICAL HISTORY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES  NO ALLERGY LIST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRESENT STATUS:**

DO YOU… SMOKE? YES NO HOW MANY PER DAY? \_\_\_\_\_\_\_\_\_\_\_\_\_ HOW LONG? \_\_\_\_\_\_\_\_\_ DRINK ALCOHOL? YES NO HOW MUCH/WEEK? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HOW LONG? \_\_\_\_\_\_\_\_\_ USE DRUGS? YES NO WHAT KIND? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HOW LONG? \_\_\_\_\_\_\_\_\_ DRINK COFFEE? YES NO HOW MANY PER DAY? \_\_\_\_\_\_\_\_\_\_\_\_\_ HOW LONG? \_\_\_\_\_\_\_\_\_ DRINK SODA? YES NO HOW MANY PER DAY? \_\_\_\_\_\_\_\_\_\_\_\_\_ HOW LONG? \_\_\_\_\_\_\_\_\_

ARE YOU IN GOOD HEALTH AT THE PRESENT TIME TO THE BEST OF YOUR KNOWLEDGE? YES NO

DO YOU CURRENTLY HAVE A PRIMARY CARE PHYSICIAN? YES NO

IF YES, WHO? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NUTRIONAL EVALUATION:**

GOAL WEIGHT: \_\_\_\_\_\_\_\_\_\_\_\_LBS.

GOAL DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNIFICANCE OF THIS DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHAT OTHER FORMAL WEIGHT LOSS PROGRAM(S) HAVE YOU TRIED?

1.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE PROVIDE DATES AND RESULTS OF WEIGHT LOSS

1.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAVE YOU TAKEN AN APPETITE SUPPRESSANT FOR WEIGHT LOSS? IF SO, WHAT? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW OFTEN DO YOU EAT OUT PER WEEK? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW OFTEN DO YOU EAT FAST FOODS PER WEEK? \_\_\_\_\_\_\_\_\_\_

FOOD ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FOOD DISLIKES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FOOD CRAVINGS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WORST FOOD HABITS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU EAT WHEN YOU’RE STRESSED: YES NO

DO YOU EAT WHEN YOU’RE BORED: YES NO

WHAT WOULD YOU TYPICALLY HAVE FOR...?

BREAKFAST: LUNCH: DINNER:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHAT TIME AND WHERE?

BREAKFAST: LUNCH: DINNER:

\_\_\_\_:\_\_\_\_ A.M. /P.M. \_\_\_\_:\_\_\_\_ A.M. /P.M. \_\_\_\_:\_\_\_\_ A.M. /P.M.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACTIVITY LEVEL:**

DESCRIBE YOUR ENERGY LEVEL (1=LOW, 10=HIGH): \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ **INACTIVE** = NO REGULAR PHYSICAL ACTIVITY, WITH LOW ACTIVE LIFESTYLE (EX. “DESK JOB”)

\_\_\_\_\_ **LIGHT ACTIVITY** = NO REGUALR PHYSICAL ACTIVITY, WITH A MODERATE ACTIVE LIFESTYLE

\_\_\_\_\_ **MODERATE ACTIVITY** = 2-3X PER WEEK ANAEROBIC AND/OR AEROBIC EXERCISES SUCH AS WALKING, JOGGING,

TENNIS, SWIMMING, CYCLING, ETC…

\_\_\_\_\_ **HEAVY ACTIVITY** = 4-5X PER WEEK CONSISTENT WEIGHT TRAINING, STAIR CLIMBING, RUNNING, CYCLING, ACTIVE

SPORTS, ETC…

\_\_\_\_\_ **VIGOROUS ACTIVITY** = 5-6X PER WEEK OF EXTENSIVE PHYSICAL EXERCISE SUCH AS “CROSS FIT”, “BOOT CAMPS”, PERSONAL TRAINER.

PLEASE DESCRIBE YOUR GENERAL HEALTH GOALS AND IMPROVEMENTS YOU WISH TO MAKE:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

THANK YOU FOR TAKING THE TIME TO FILL OUT YOUR NEW PATIENT PACKET. THIS HEALTH ASSESMENT WILL ASSIST AHWATUKEE WEIGHT LOSS AN ESTABLISHING YOUR PERSONALIZED MEDICAL WEIGHT LOSS AND MANAGEMENT PROGRAM. WE LOOK FORWARD TO GIVING YOU THE STEPS TO SUCCESS.