Science Based Slimming
Weight Loss Program Questionnaire

First Name: _____ Middle Name: _____ Last Name: _____

Preferred Name: _____ Male ____ Female ____ # of children _____

Address: _____ City: _____ State: ____ ZIP: ____

Birth Date: ___/___/_____ Age: ____ Primary Physician: _____

Marital Status: Single ___ Married ___ Divorced ___ Widowed ___

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Work Phone: (_____) _____-_____ Email: _____

Occupation: _____

Who recommended you to this office? _____ Date: _____

Please do your best to answer the following questions

SLEEP/REST:

A. Average number of hours you sleep per night? >10 ___ 8-10 ___ 6-8 ___ <6 ___
B. Do you have trouble falling asleep? Yes ___ No ___
C. Do you wake up and are unable to get back to sleep for more than 5 minutes? Yes ___ No ___
D. Do you feel rested upon awakening? Yes ___ No ___
E. Do you snore? Yes ___ No ___
F. Have you been diagnosed with sleep apnea? Yes ___ No ___
If so, do you use a C-PAP or BiPAP while sleeping? Yes ___ No ___

PAST MEDICAL AND SURGICAL HISTORY:
Have you had or presently have any of the following

Allergies - Environmental: Yes ___ No ___
Allergies - Food: Yes ___ No ___
Autoimmune Disease: Yes ___ No ___
Candida Syndrome (Yeast): Yes ___ No ___
Celiac disease: Yes ___ No ___
Chronic Fatigue Syndrome: Yes ___ No ___

Depression:	Yes ___ No ___
Diabetes (Type I):	Yes ___ No ___
Diabetes (Type II):	Yes ___ No ___
Eczema: Diabestes (Type I):	Yes ___ No ___
Fibromyalgia Symptoms:	Yes ___ No ___
Heart Attack/ Angina:	Yes ___ No ___
Heart Failure:	Yes ___ No ___
Heart Valve Problems:	Yes ___ No ___
High Blood Fats (Cholesterol, Triglycerides):	Yes ___ No ___
High Blood Pressure:	Yes ___ No ___
Hypoglycemia:	Yes ___ No ___
Multiple Chemical Sensitivities:	Yes ___ No ___
Polycystic Ovary Syndrome:	Yes ___ No ___
Poor Immune Function (Frequent Infections):	Yes ___ No ___
Sinusitis:	Yes ___ No ___
Thyroid Disease (Hyperthyroid):	Yes ___ No ___
Thyroid Disease (Hypothyroid):	Yes ___ No ___

Please list any major or minor surgeries you have had, including dates:

_____

_____

_____

GENERAL HEALTH

Do you currently or within the past 6 months present with any of the following symptoms

Cold Hands & Feet:	Yes ___ No ___
Cold Intolerance:	Yes ___ No ___
Fatigue:	Yes ___ No ___
Heat Intolerance:	Yes ___ No ___
Night Sweats:	Yes ___ No ___
No Dream Recall:	Yes ___ No ___
Distorted Sense of Smell:	Yes ___ No ___
Distorted Taste:	Yes ___ No ___
Headache:	Yes ___ No ___
Muscle Spasms:	Yes ___ No ___
Panic Attacks:	Yes ___ No ___
Binge Eating:	Yes ___ No ___
Bulimia:	Yes ___ No ___
Carbohydrate Craving:	Yes ___ No ___
Salt Craving:	Yes ___ No ___
Bad Teeth:	Yes ___ No ___
Bleeding Gums:	Yes ___ No ___
Bloating of Lower Abdomen:	Yes ___ No ___
Bloating of Whole Abdomen:	Yes ___ No ___

Burping:	Yes ___ No ___
Canker Sores:	Yes ___ No ___
Cracking of Corner of Lips:	Yes ___ No ___
Reflux:	Yes ___ No ___
Full Feeling After Meals:	Yes ___ No ___
Heartburn:	Yes ___ No ___
Periodontal Disease:	Yes ___ No ___
Sore Tongue:	Yes ___ No ___
Bumps on Back of Upper Arms:	Yes ___ No ___
Cellulite:	Yes ___ No ___
Dark Circles Under Eyes:	Yes ___ No ___
Lackluster Skin:	Yes ___ No ___
Soft Nails:	Yes ___ No ___
Thickening of Fingernails:	Yes ___ No ___
Thickening of Toenails:	Yes ___ No ___
Bad Breath:	Yes ___ No ___
Sinus Infections:	Yes ___ No ___
Sinus Fullness:	Yes ___ No ___
Palpitations:	Yes ___ No ___

PLEASE ANSWER THE FOLLOWING QUESTIONS

A. How often have you taken antibiotics?

Childhood:	<5 times ____	>5 times ____
Teen:	<5 times ____	>5 times ____
Adult:	<5 times ____	>5 times ____

B. How often have you taken oral steroids (e.g., Cortisone, Prednisone, etc.)?

Childhood:	<5 times ____	>5 times ____
Teen:	<5 times ____	>5 times ____
Adult:	<5 times ____	>5 times ____

C. What medications are you taking now? Include non-prescription drugs

Medication Name	Date Started	Dosage	Reason

Medication Name	Date Started	Dosage	Reason

Are you allergic to any medications? Yes ___ No ___

If yes, please list:_____

_____

D. List all vitamins, minerals, and other nutritional supplements that you are taking now.

Vitamin/ Mineral/ Supplement Name	Date Started	Dosage	Reason

E. **FOR WOMEN ONLY** (Questions E-K) Have you ever used birth control pills? Yes ___ No ___ If yes, when? _____

F. Are you taking the pill now? Yes ___ No ___

G. Did taking the pill agree with you? Yes ___ No ___

H. Do you currently use contraception? Yes ___ No ___

If yes, what type? _____

I. Are you in menopause? Yes ___ No ___

If yes, age at last period: _____

Do you Take: Estrogen ___ Ogen ___ Estrace ___ Premarin ___ Progesterone ___ Provera ___

Other _____

J. How long have you been on hormone replacement therapy (if applicable)? _____

K. In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? Yes ___ No ___

L. Are you on a special diet?

Ovo-lacto ___ Vegetarian ___ Blood Type Diet: ___ GAPS: ___
Diabetic ___ Vegan ___ Dairy Restricted ___
Other: _____
_____

M. Is there anything special about your diet that we should know? Yes ___ No ___
Explain:_____
_____

N. Do you have symptoms immediately after eating, such as belching, bloating, hives, etc? Yes ___ No ___
If yes, are these symptoms associated with any particular food or supplement? Yes ___ No ___
Please name the food or supplement and symptoms:_____
_____

O. Do you feel you have *delayed* symptoms after eating certain foods (symptoms may not be evident for 24 hour of more), such as fatigue, muscle aches, sinus congestion, etc?

P. Do you feel better if you don't eat at all?

Q. In general, do you feel worse when you eat?

R. Do you notice abdominal bloating taking fiber supplements?

S. Do you feel much **worse** when you eat a lot of:
High Fat Foods ___ Refined Sugar (junk food) ___ Fried Foods ___
High Protein Foods ___ 1 or 2 Alcoholic Drinks ___ High Carb Foods ___

T. Do you feel much **better** when you eat a lot of:
High Fat Foods ___ Refined Sugar (junk food) ___ Fried Foods ___
High Protein Foods ___ 1 or 2 Alcoholic Drinks ___ High Carb Foods ___

U. Have you ever had a food that you craved or really "binged" on over a period of time? Yes ___ No ___ If yes, what food(s)? _____

V. Do you eat compulsively or in response to emotions? (If yes, please describe.) _____
_____

W. Do you have an aversion to certain foods? Yes ___ No ___ If yes, what food(s)? _____
_____

X. How often do you grocery shop? _____
_____

Y. Where do you grocery shop?_____
_____

Z. What is your monthly grocery budget? _____
_____

AA. Please check any of the following statements that describe your eating patterns.
__ I usually don't realize I'm hungry until I'm ravenous.
__ I'm often not satisfied until I'm stuffed.
__ I can't say no to foods like chocolate or chips.
__ I follow the "see food diet": When it's there, I eat it.
__ I usually quit eating when I feel like I've comfortably had enough.
__ I always worry whether the foods I eat will make me gain or lose weight.
__ The only way I know to stop eating is when the plate is "clean"

__ I don't really think about what I eat, I just grab whatever is available.
__ Most of the time, I eat only when I am hungry.
__ I often get so hungry that rich foods are more appealing than lighter ones.
__ I usually quit eating because I lose interest in food as I become satisfied.
__ I stop eating because I think I should.
__ I like nutritious foods, but I forget to have them.
__ I feel that I can never get enough of certain foods I think I shouldn't eat.
__ I often let myself get so hungry that I eat more than I want.

BB. Please fill in the charts below with information about your bowel movements:

FREQUENCY	**X**
More than 3x/day	
1-3x/day	
4-6x/week	
2-3x/week	
1 or fewer x/week	

CONSISTENCY	**X**
Soft and well formed	
Often floats	
Difficult to pass	
Diarrhea	
Thin, long or narrow	
Small and hard	
Loose but not watery	
Alternating between hard and loose	

COLOR	**X**
Medium brown consistency	
Very dark or black	
Greenish color	
Blood is visable	
Varies a lot	
Dark brown	
Yellow, light brown	
Greasy, shiny appearance	

CC. Intestinal Gas: Daily ____ Occasionally ____ Excessive ____
Present with pain ____ Foul smelling ____ Little odor ____

DD. Have you ever used alcohol? Yes ___ No ___
No longer drinking alcohol ___
Average 1-3 drinks per week ___
Average 4-6 drinks per week ___
Average 7-10 drink per week ___
Average >10 drinks per week ___

EE. Have you ever used recreational drugs? Yes ___ No ___

FF. Have you ever used tobacco? Yes ___ No ___
If yes, number of years as a nicotine user: ____ Amount per day: ___ Year quit: ___
If yes, what type of nicotine have you used? Cigarette ___ Smokeless ___
Cigar ___ Pipe ___ Patch/Gum ___

GG. Have you, to your knowledge, been exposed to toxic metals on your job or at home?
Yes ___ No ___ If yes, which one(s)? Lead ___ Arsenic ___ Aluminum ___
Cadmium ___ Mercury ___

HH. Do odors affect you? Yes ___ No ___

II. Do you have any adverse reaction to caffeine? Yes ___ No ___

JJ. When you drink caffeine, do you feel: Irritable or "wired" ____ Aches and Pains ___

KK. Do you adversely react to:

Monosodium Glutamate (MSG):	Yes ___ No ___
Aspartame:	Yes ___ No ___
Bananas:	Yes ___ No ___
Garlic:	Yes ___ No ___
Onion:	Yes ___ No ___
Cheese:	Yes ___ No ___
Citrus Fruits:	Yes ___ No ___
Chocolate:	Yes ___ No ___
Alcohol:	Yes ___ No ___
Red Wine:	Yes ___ No ___
Sulfite containing foods (wine, dried foods, salad bar):	Yes ___ No ___
Preservatives:	Yes ___ No ___

Other:_____

LL. Are you effected by any of the following?

Cigarette smoke: Yes ___ No ___

Perfume/Colognes: Yes ___ No ___

Auto/Diesel exhaust fumes: Yes ___ No ___

Other: _____

MM. In your work environment are you exposed to chemicals, electromagnetic radiation, or mold? Yes ___ No ___

NN. Have you ever turned yellow (jaundice)? Yes ___ No ___

OO. Have you ever been told you have Gilbert's Syndrome? Yes ___ No ___

PP. Do you have any known history of significant exposure to any harmful chemicals such as the following:

Herbicides ___ Insecticides ___ Pesticides ___ Organic Solvents ___

Heavy Metals ___ Other: _____

QQ. Please list any hobbies or leisure activities you enjoy:

_____

_____

_____

RR. Do you exercise regularly? Yes ___ No ___

If so, how many times a week? 1x ___ 2x ___ 3x ___ 4x or more ___

When you exercise, how long is each session? <15 min ___ 16-30 min ___

31-45 min ___ >45 min ___

What type of excretes is it? _____

_____

SS. What is the attitude of those close to you about your weight loss plans?

Supportive ____

Non-Supportive ___

PERSONAL:

A. On a scale of 0-10, how happy are you? If "0" is very unhappy and "10" is very happy: ___
B. Do you feel your life has meaning and purpose? Yes ___ No ___
C. Do you believe stress is presently reducing the quality of your life? Yes ___ No ___
D. Do you like the work you do? Yes ___ No ___
E. Do you spend the majority of your time and money trying to fulfill responsibilities and obligations? Yes ___ No ___
F. Do you feel you have and excessive amount of stress in your life? Yes ___ No ___
G. Do you feel you can easily handle the stress in your life? Yes ___ No ___
H. Daily Stressors (Rate on a scale of 1-10)
    A. Work ___ Family ___ Social ___ Finances ___ Health ___ Other ___
I. Would you describe your experience as a child in your family as happy and secure? Yes ___ No ___
J. Did you feel safe growing up? Yes ___ No ___
K. Have you been involved in an abusive relationship in your life? Yes ___ No ___
L. Was alcoholism or substance abuse present in your childhood home, or is it present in your relationships? Yes ___ No ___

Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your lie, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment

M. Do you currently feel safe in your home? Yes ___ No ___
N. Do you feel safe, respected, and valued in your current relationship? Yes ___ No ___
O. Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse? Yes ___ No ___
P. Have you ever sought counseling? Yes ___ No ___
Q. Are you currently in therapy? Yes ___ No ___
R. Would you feel safer discussing any of these issues privately? Yes ___ No ___