INTAKE FORM

Health Assessment Patient Questionnaire

Name: _____ Date: _____

How you heard about us: _____

Primary reason for your visit: _____

Top 2 goals you would like to achieve by working with ***Love to Live Well***:

1. _____
2. _____

Top 2 reasons you want to achieve them (what motivates you to make these goals happen?):

1. _____
2. _____

Background Information

Age: _____ Birth date: _____ Preferred phone number: _____

E-mail: _____ Occupation: _____

Work hours: _____ Marital status: _____

Highest level of education: _____

Please list the people in your household and their relationships to you:

_____

General Health Information

Physician's name: _____ Physician's phone: _____

Physician's address: _____

Date of most recent physical exam: _____ Date of most recent blood tests: _____

How do you rate your health? ◯ Poor ◯ Fair ◯ Good ◯ Excellent

Height (feet & inches): _____ Weight (lb.): _____

Ideal Body Weight (what **you** would like to weigh): _____ Year you last weighed this _____

REVIEW OF SYSTEMS (check all that you currently have or are concerned about)

Respiratory	**Cardiovascular**
☐ Shortness of breath	☐ High blood pressure
☐ Coughing	☐ Heart disease/heart attack
☐ Asthma or wheezing	☐ Congestive heart failure
☐ Emphysema	☐ Heart murmur
☐ Snoring	☐ Irregular heartbeat or palpitations
☐ Daytime sleepiness	☐ Chest pain or discomfort
☐ Disturbed sleep	☐ Ankle or feet swelling
☐ Sleep apnea	☐ Varicose veins
☐ History of pneumonia, chronic bronchitis, or COPD	☐ Blood clots or clotting disorders
Genitourinary	**Endocrine**
☐ Difficulty urinating	☐ Diabetes mellitus
☐ Urinary incontinence (leaking urine)	☐ High cholesterol
☐ Inability to empty bladder fully	☐ Thyroid disease
☐ Recurrent urinary tract infections (UTIs)	☐ Gout
☐ Infertility	☐ High triglycerides
☐ Sexual problems	**Musculoskeletal**
☐ Abnormal menstrual periods	☐ Aching muscles or joints
☐ Enlarged prostate	☐ Lower back pain/disc problems
	☐ Arthritis

Gastrointestinal

- ☐ Nausea/vomiting
- ☐ Abdominal/stomach pain
- ☐ Heartburn/acid reflux
- ☐ Belching/burping
- ☐ Ulcer disease
- ☐ Rectal bleeding or blood in stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gallbladder disease/gallstones
- ☐ Celiac disease
- ☐ Hernia
- ☐ Hemorrhoids

Skin and Hair

- ☐ Skin sores or infections (boils, ulcers, skin fold irritations)
- ☐ Bruises easily
- ☐ Chronic rashes or dermatitis or eczema
- ☐ Excessive facial/ body hair (women only)

Cancer (list type):

_____

Other Serious Medical Conditions (list individually):

1. _____
2. _____
3. _____
4. _____

Other

- ☐ Low energy level
- ☐ Depression
- ☐ Bipolar disorder
- ☐ Attention deficit disorder (ADD) or attention deficit and hyperactivity disorder (ADHD)
- ☐ Anxiety disorder or panic attacks
- ☐ Obsessive-compulsive disorder (OCD)
- ☐ Psychological or psychiatric care
- ☐ History of child abuse, rape, or molestation
- ☐ History of being subjected to any physical or verbal abuse
- ☐ Binge eating
- ☐ Bulimia
- ☐ Anorexia
- ☐ Anemia
- ☐ Headaches or migraines
- ☐ Peri/post-menopausal

Do you have a family history of any of the following? (Check all that apply)

- ☐ high blood pressure
- ☐ thyroid disease
- ☐ diabetes
- ☐ obesity
- ☐ high blood cholesterol
- ☐ heart disease
- ☐ cancer
- ☐ other (list) _____

List the types of surgeries you have had (including the year):

List all prescription and over-the-counter medications that you currently take (include the dosages): (or bring a list of these with you for my records)

List all vitamins, minerals, supplements, and herbs that you take: (or bring a list of these with you for my records)

Stress/Coping Information

Do you smoke (Y/N)? _____ If so, how much? _____ cigarette packs/week

Do you drink alcohol (Y/N)? _____ If so, how often? _____ days/week

What type of alcohol? _____

Do you consume energy drinks like Red Bull, 5-Hour Energy, etc.(Y/N)? _____

If so, what type? _____ How often? _____ drinks/week

How many hours of sleep do you average per night? _____ Is your sleep restful (Y/N)? _____

On a scale from 1 (low stress) to 5 (high stress), how would you rate your daily stress level?

◯1 ◯2 ◯3 ◯4 ◯5

How do you cope with stress in your daily life?

_____

What are your top stressors (things that make you stressed)?

_____

Who are the top 3 people in your social support structure (relationships: e.g. spouse, child, etc.)?

On a scale from 1 (weak) to 5 (strong), how would you rate your social support network?

1 2 3 4 5

Is your work/home environment supportive of making changes in eating better, moving more, and stressing less? If not, please explain.

On a scale of 1 (not ready) to 5 (very ready), how ready are you to make lifestyle changes?

1 2 3 4 5

On a scale of 1 (not at all confident) to 5 (very confident), how confident are you to make lifestyle changes?

1 2 3 4 5

What makes it hard for you to lose weight and keep it off?

Nutrition Information

What one or two things would you like to change about your diet?

What dietary limitations (dislikes, intolerances, avoidance of textures/tastes) do you have?

List any food allergies/sensitivities or religious/cultural beliefs that affect your health care/diet:

In the following chart, describe when and what you usually eat in a typical day.
(Write "None" if you do not eat that meal or snack.)

MEAL	TIME	FOODS EATEN	AMOUNTS
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			

Do you have difficulty getting meals prepared (Y/N)? _____ If so, why? (select all that apply)

- ☐ Time/prep issues
- ☐ Don't like to cook
- ☐ Don't know how to cook
- ☐ Other (please specify) _____

Physical Activity Information

What is the most physically active thing you do in an average day?

_____

What, if any, regular exercises (or activities) do you do? How often and for how long do you participate?

_____

_____

Are there any reasons that may limit your physical activity? If yes, please explain the reasons.

_____

_____

Food/Activity Snapshot

For this next section, please think of the last week of your food intake/activity:

_____ Servings of **veggies**/day you ate (1 serving = ½ cooked or 1 c raw veggies)

_____ Servings of **fruits**/day you eats (1 serving = ½ c canned, fresh, or frozen fruit)

_____ Servings of **fruit juice**/day you drank (1 serving = ½ c)

_____ Servings of **soda**/day you drank (1 serving = 12 oz can)

_____ Servings of **milk or yogurt**/day you drank/ate (1 serving = 8 oz)

Type of milk you drink/yogurt you eat**:**

☐ skim ☐ 1% ☐ 2% ☐ whole

_____ Number of **sweets** (candy, candy bars, chocolates, cookies, ice cream) you eat/day or week (select day or week, whichever fits best)

◯ day ◯ week

_____ Number of **snacks** you eat/ day or week (select day or week, whichever fits best)

◯ day ◯ week

_____ Number of times you **skip a meal**/day or week (select day or week, whichever fits best)

◯ day ◯ week

_____ Times you eat out at a **casual dining restaurant (sit-down restaurant)**/day or week (select day or week, whichever fits best)

◯ day ◯ week

_____ Times you eat out at a **fast food** restaurant/day or week (select day or week, whichever fits best)

◯ day ◯ week

_____ Times you eat **fried foods** (French fries, fried chicken, breaded meats, potato/tortilla chips) /day or week (select day or week, whichever fits best)

◯ day ◯ week

_____ Hours/day you watch **TV or play video games**.

_____ Hours/day you **sit at a computer**.

Was this a typical week for you (Y/N)? ____ If not, explain.

_____

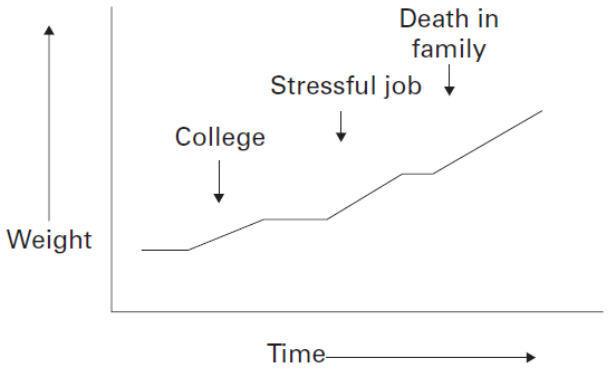
For this next section, please think of the <u>a typical week</u> and list the following:

What are the **3 most common beverages** you drink?	What are the **3 most common foods** you eat?	What are the **3 most common snacks** you eat?	What are the **top 3 ways you like to be active**?

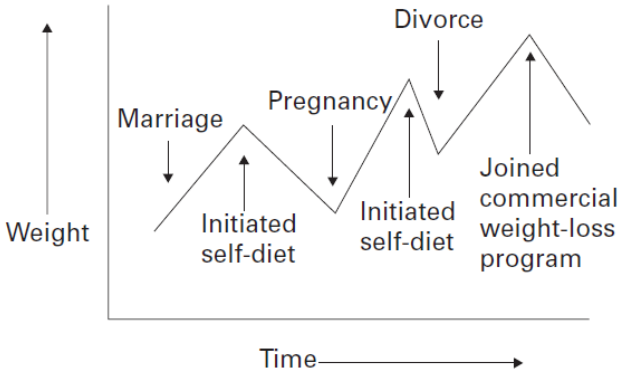
Weight History Graph

Most people can relate changes in their weight to different life events. The following graphs illustrate two examples of how people have gained weight.

Progressive (or Ratcheting) Weight Gain



Weight Cycling or "Yo-Yo" Weight Gain



Please draw a graph of your weight gain. Mark *life events* and *diet attempts* that have contributed to your current weight. Please include ages at points where your weight changed.