Name______________________ DOB_______________

Telephone _________________

Address____________________ Email _______________

Primary care physician/provider and phone number ____________________

Current health problems ______________ Medications___________________

_____________________________________ ______________________________

_____________________________________ ______________________________

_____________________________________ ______________________________

Over the Counter (OTC) meds or supplements ______________________________

____

Medication allergies ____________________ Food allergies_________________

Fertility status: Actively trying ___Pregnant ___Actively preventing or not possible___

Past Medical History (as relates to obesity and obesity medication treatment choices):

___eating disorder ___glaucoma ___thyroid cancer

___multiple endocrine neoplasia ___PCOS ___pancreatitis

___gallstones ___kidney stones ___substance abuse issues

___seizures ___osteoporosis ___childhood trauma, DV

Weight history:

When did you first consider yourself overweight? _________________________________

How many times have you lost more than 10 pounds? _____________________________

What do you think worked for you? ____

Current activity:

How many times per week do you CURRENTLY engage in exercise for 20 minutes or more at a time? ____________

How would you describe your current activity level? Sedentary ___I am lightly active (housework, chase children, yardwork)___I walk a mile or more regularly ___ I can jog a mile or more regularly ___ I exercise an hour or more at least 3 times per week___

Current Social and Food Habits:

Who lives at home? ____

Who shops for groceries?__________________ Who cooks ?________________________

How often do you eat out?_________________

What do you feel are your biggest triggers to overeat? ____________________________

____

Daily caffeine intake __________________ Weekly alcohol intake ________________

Do you smoke or vape? ________________

24 hour diet recall: Write down everything you have eaten in the past 24 hours

____

____

____

Current Sleep habits:

Do you feel rested when you awaken? _____ Do you have a regular schedule? _____

TV in the bedroom? _____ Do you leave it on to fall asleep?_____ Other lights? _______

Sleep apnea _________ White noise ______ Other sleep aids ____________________

NAME: ____________________________

Date:________ Height ______ Weight _________ BMI_________

BP__________ HR__________ Abd Circ _______ Neck _______

Calculated RMR F: 10(__kg) + 6.25 (ht ___cm) – 5(age) – 161 = ______________

M: + 5 = _______________

First goal: ____

Macros: _________protein _________carbs______________fat

Exercise: ____

Medication:_____________________ Received on Account:___________

Follow up:_____________________ Signed____________________

Date:________ Weight ______ Change _________ %_________

BP__________ HR__________

Dietary adjustments: _________calories _________protein________carb______fat

Exercise:____

Medication__________________________ Received on account___________

Follow up __________________________ Signed____________________

What current physical or mental health issues are you hoping weight loss will improve?

____

On a scale of 1-10, how motivated do you feel to make small changes in your lifestyle to achieve your goals? __________

How much is fear of failure keeping that number from being a 10? __________________

Lab results:

Is there anything else you would like me to know about you?

PHQ9 Score

GAD 7 Score

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _______

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).	TOTAL:			

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
Not difficult at all	______
Somewhat difficult	______
Very difficult	______
Extremely difficult	______