FUNCTIONAL WEIGHT LOSS INTAKE FORM

If you are a new patient, please complete all fields. If you are an existing patient, please complete your name and DOB only and skip to Section 2.

SECTION 1

Name: _____ DOB _____ Today's Date: _____

Address: _____ City / State / Zip:_____

Best contact phone number : _____ Email: _____

Who referred you to our office?: _____

SECTION 2 – Please answer the following questions on a scale of 1-10. 1 = very poor 10 = very good

How do you rate your current state of overall health? _____ If not a 10, what do you need to do to get you to a 10? _____

How do you rate your current diet? _____ If not a 10, what needs to change to get you to a 10?_____

_____

How do you rate your current level of motivation to get healthier (more active/eating better/less body weight)? _____

If not a 10 now, what do you need to do to get you to a 10? _____

_____

Why do you want to get healthier (be as specific as possible)? _____

_____

SECTION 3 – Please fill in the blanks and check boxes as needed.

Please list all current prescription medications: _____

Please list all over the counter medications (used 1 x per week or more): _____

Please list all supplements/vitamins you take regularly: _____

History of high blood pressure? □ Self □ Mother □ Father

History of diabetes? □ Self □ Mother □ Father If yes: □ Type I □ Type II

History of cancer? □ Self □ Mother □ Father Type: _____

Any problems with thyroid or other autoimmune diagnoses? □ Self □ Mother □ Father Type: _____

Any Surgeries? □ No □ Yes (please list procedure and year performed)_____

_____

FUNCTIONAL WEIGHT LOSS INTAKE FORM (cont.)

SECTION 4

Please list your present weight (if known): _____ Height: _____ Desired Weight: _____

Have you tried other weight loss programs? □ Yes □ No If yes, which ones? _____

_____

How often do you eat out? □ 1x/week or more □ 1x/every two weeks □ 1x/month or less

What restaurants do you frequent? _____

How often do you eat at fast food restaurants? □ 1x/week or more □ 1x/every two weeks □ 1x/month or less

Any Food allergies? □ Yes □ No If yes, list here: _____

_____

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review Gard Wellness Center's Notice of HIPAA Privacy Practices for protected health information. These are available on our website, at the Reception Desk and on the table in the Reception room.

Print Patient's Name _____Patient's Signature_____Date:_____

Consent to Treat a Minor: (Minor's Printed Name) _____

Parent / Guardian's Signature Authorizing Care _____ Date_____

SIGNATURE OF PHYSICIAN: _____ Date: _____