INITIAL WEIGHT LOSS CONSULTATION

Name: ______________________________________ Date: ____________________________________

Date of Birth: __________________ Age: ____________ Weight: __________ Height: __________________

Weight loss goal: ____

Name of Family Physician who will receive your progress reports: ____

Office Address: ____

Office Phone: ____

Review of Symptoms

Do you now or have you ever had any problems related to the following systems? Please check all that apply.

General Skin	Pulmonary	Gastrointestinal	Genitourinary
____No active problems ____Fatigue ____Fever ____Chills ____Night Sweats ____Rash ____Weight gain ____Weight loss ____Skin ulcers/cellulitis ____Skin fold irritations ____Skin fold infections ____ Hair loss ____Dry Skin	____No active problems ____Choking at night ____Frequent waking ____Daytime drowsiness ____Wheezing ____Emphysema ____Snoring ____Short of breath ____Persistent cough ____Asthma ____COPD	____No active problems ____Heartburn/acid reflux ____Abdominal paid ____Constipation ____Diarrhea ____Blood in stool ____Irritable bowel ____Nausea ____Vomiting ____Change in appetite	____No active problems ____Urinary incontinence ____Blood in urine ____Burning on urination ____Prostate problems **Gynecological** ____Vaginal infections ____Irregular periods Last menstrual period ________________ Are you pregnant _______ Current Contraception ______________________
Cardiac	**Neurological**	**Musculo –Skeletal**	**Psychiatric**
____No active problems ____Chest pain/angina ____Heart attack/CAD ____Swelling of ankles ____Irregular heartbeat ____Palpitations ____Heart murmur	____No active problems ____Dizziness ____Migraines/headaches ____Numbness/tingling ____Hearing loss ____Vision Loss	____No active problems ____Back/neck pain ____Difficulty walking ____Exercise limitations ____Joint pain ____Limited mobility---use cane, crutch, or wheelchair	____No active problems ____Depression ____Sexual abuse ____Alcohol abuse ____Dipolar disorder ____Anxiety/panic issues ____ADD/OCD ____Drug Abuse ____ Eating Disorder

Medical History – Please check all that apply

___Anemia ___Asthma ___Tuberculosis ___Incontinence ___H-pylori

___Bleeding disorder ___COPD ___HIV/AIDS ___Thyroid problems ___Gastritis

___Blood clots in legs/lungs ___Emphysema ___Hepatitis ___Heartburn/reflux ___Hiatal Hernia

___Stroke/TIA/Seizure ___Sleep apnea ___Kidney disease ___Diabetes ___Stomach ulcers

___Congestive heart failure ___High cholesterol ___ Rheumatic fever ___Kidney stones ___High blood pressure

___Previous heart attack ___High triglycerides ___Gout ___Cancer_____ ___Arthritis

___Irregular heart beat ___Stent placed __________ ___Diverticulitis

___Stress test ___Echo ___Coronary artery disease ___Polycystic Ovarian Syndrome (PCOS)

___Liver disease ___ Liver disease requiring protein restriction

___Kidney disease requiring protein restriction

Past Surgical History
(Please check all that apply and write year of surgery next to procedure)

___Gallbladder ___Hernia ___Hemorrhoids ___Heart Surgery
___C-Sections ___Breast ___Colonoscopy ___Angioplasty/Stents
___Hysterectomy ___Appendix ___Colon surgery ___Previous weight loss surgery
___Tubal Ligation ___Thyroidectomy ___Knee surgery ___Pacemaker
___Back surgery ___Joint Replacement Surgery ___Other surgery_______________
____

Complications with any surgery: ____

MEDICATIONS: Please list all daily medications including over the counter medications and vitamins, herbs or supplements

Name	Dosage	Frequency Year Started

MEDICATION ALLERGIES: Please list any known allergies or sensitivities and the reaction you had.

Name	Reaction

OTHER ALLERGIES AND SENSITIVITIES: Please list any known allergies or sensitivities and the reaction you had.

NAME	REACTION
Latex (yes) (no)	
IVP Dye (yes) (no)	
Tape (yes) (no)	
Iodine (yes) (no)	

FAMILY HISTORY – PLEASE CHECK ALL THAT APPLY

	Diabetes	High Blood Pressure	Heart Attack	Stroke	Sleep Apnea	Cancer
Mother						
Father						
Brother						
Sister						
Grandmother						
Grandfather						

SOCIAL HISTORY – PLEASE CHECK ALL THAT APPLY

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed
Religious preference :( ) Catholic ( ) Baptist ( ) Methodist ( ) Lutheran ( ) Jehovah Witness ( ) Atheists ( ) Other____________
Education: ( ) Grade School ( ) High School ( ) College ( ) Graduate School ( ) GED
What type of work do you do?
____

Number of people living in your home:
____

Smoking History: ( ) Never smoked ( ) Smoke now ( ) Used to smoke, stopped _______________ packs/day for ______yrs
Chemical dependency: ( ) None ( ) Using now ( ) Used to use Substance used
____

Alcohol history: ( ) Beer ( ) Wine ( ) Liquor How often? ( ) Daily ( ) Weekly ( ) Occasionally ( ) Rarely
Exercise history: ( ) Rarely ( ) occasionally ( ) 1-2 times a week ( ) 3-4 times a week ( ) 5 times or + a week
Has a doctor or healthcare professional ever told you not to exercise? ____
Do you know of a reason why you should not exercise? ____

Food Allergies/ Sensitivities

__Cocoa __Milk Protein __Corn __Soy __Eggs __Gluten __Aspartame
__MSG __Lactose __Other:________________ ___ Vegetarian

Weight- Loss Eating Habits (Please check all that apply)

__ Eating high-fat foods __Eating too many sweets __Eating too quickly __Uncontrollable binges
__Overeating when alone __Using food as reward __Only eat once a day __ Eat out too much
__ No meal planning __ No meal packing __Purge after meals __ Use laxative or diuretics
__ Waken hungry at night __
__Overeating at social events __ Drink too much soda/ tea/ sweetened beverage __Eating in reaction to boredom

Foods you crave: ____
Foods you dislike: ____
How often do you eat out: ____________________________________ where most often: ______________________
Who plans meals: _________________________ Who Cooks: ____________________ Who Shops: _________________

Typical Breakfast	Typical Lunch	Typical Dinner	Snacks
______________	_______________	_______________	_______________
______________	_______________	_______________	_______________
______________	_______________	_______________	_______________
______________	_______________	_______________	_______________
Time eaten:	Time eaten:	Time eaten:	Time eaten:
Where:	Where:	Where:	Where:
With whom:	With whom:	With whom:	

Maximum Weight (non-pregnant) ______ Year: _____ Goal Weight______ Last time at this weight: ______
In what time frame do expect to be at your goal weight: ___________

Psychosocial History:

Are you at present undergoing any major lifestyle change (marriage, divorce, job change, death of someone important to you?) If so describe: ____

What other commitments do you have that might interfere with you participating in with your weight loss and wellness program? ____

When you are under stressful situations at work or family related, do you tend to eat more? Explain: ______________
____

What benefits do you hope to gain from being in this program other than losing weight? _________________________
____

Who do you feel will be supportive of your weight loss and changes in lifestyle? (Check and name your choices)

( ) Spouse ( ) Children ( ) Roommate(s) ( ) Parent ( ) Friend(s) ( ) Co- worker(s) ( ) other

_________ _________ ___________ ________ _______ ____________ ________

Who do you feel may NOT be supportive of your weight loss and changes in lifestyle? (Check and name your choices)

( ) Spouse ( ) Children ( ) Roommate(s) ( ) Parent ( ) Friend(s) ( ) Co- worker(s) ( ) other

_________ _________ ___________ ________ _______ ____________ ________

List weight loss methods you have tried, please be as specific as possible

(eg. Nutrisystem, Jenny Craig, Starvation, Medications, Spa, Hypnosis, Weight Watchers, Adkins, South Beach, HCG...)

Weight Loss Method Ex: Grapefruit Diet	**Amount of time weight loss maintained** Ex: 2 months	**Reason why you stopped treatment** Ex: interaction with meds	**Problems during treatment** Ex: dizziness

If you have already had surgery and are here for aftercare, please fill out this section

Surgery date: _________________ ( ) Band ( ) Bypass ( ) Sleeve ( ) Plication

Surgeon:________________________

Weight at time of surgery: __________ Lowest weight achieved _________ How many fills have you had?___________

Current diet: ( ) Clear Liquids ( ) Pureed ( ) Soft ( ) Regular

Notes:____
____
____

Physician/NP: ____ Date: _______________

12 Reasons

"Why I Want to Reach My Goal Weight"

Name: ____ **Date:** __________________________________

Before writing your reasons down, give them some thought. It is important that these 12 reasons be true personal goals and desires. They should not be generalizations or what you think would please others because they will be used as your "personal motivator."

1____

2____

3____

4____

5____

6____

7____

8____

9____

10____

11____

12____

Take a few moments from time to time each day to thoughtfully read through this list. This is called mental programming. The original of your 12 reasons list is retained in your medical file. You will be given a copy to carry at all times. We suggest that you also transfer your list onto a 3 x 5 card which may be more convenient.

Make a promise to yourself now: “I will read the entire card whenever I am confronted with a difficult food situation.” Reading the list will clearly reinforce your personal commitment to take control of your health and self-esteem.