Weight Loss Intake Form

Name:_____ Date of Birth:_____/_____/_____
Address:_____
City:_____ State/Province:_____ Zip/Postal code:_____
Phone #:_____ Email:_____
Male / Female
Emergency Contact:_____ #: _____
How did you hear about us?_____
What are your main weight issues and goals?_____
Are you currently on any weight loss programs or special diet? Yes / No If Yes, please explain:_____
_____
Do you smoke? Yes No If Yes, how many per day:_____
Do you consume alcohol? Yes No If Yes, what is your weekly consumption?_____
Do you exercise regularly? Yes/ No If Yes, please specify:_____
Do you have any type of injury or have you had any type of operation in the last 12 months? Yes /No
If Yes, please specify:_____
Do you have any Allergies Yes/ No If Yes, please list all allergies and/or reactions to drugs, food, latex, etc.:
_____
_____
FEMALE PATIENTS:
Have you had a Hysterectomy? Yes/ No If Yes, please list date and explain reason:_____
_____
Number of Pregnancies:_____ Live Births:_____ Date of Last Menstrual Cycle:_____
MALE PATIENTS:
Have you had a Vasectomy? Yes /No If Yes, please list date:_____
Please list all Surgeries and other Hospitalizations:
Reason:_____ Year:_____ Hospital:_____
Reason:_____Year:_____ Hospital:_____
Reason:_____ Year:_____ Hospital:_____

Have you ever had weight loss surgery? Yes / No, If Yes, date of procedure:_____
If yes to above, Highest Pre-Surgery Weight:_____ Lowest Post Surgery Weight:_____
What do you feel are the main contributors to having excess weight? (Circle all that apply):

Child Birth Sleep Issues Stress Family History Hormone Changes Excessive Snacking

Alcohol Intake Medical Condition Late Night Eater Busy Lifestyle Emotional Eater
Sedentary Lifestyle Menopause Other:_____

What foods do you crave most often and how often do you eat these foods?
_____ _____

What methods have you used in the past for weight loss? (Circle all that apply):

Exercise Diet Modifications Prescription Medications Weight Loss Pills Therapy Injections
Please list details of items marked above:_____
Do you experience any potential weight loss obstacles below?

Skipping Meals Binge Eating Stress Eating Psychological Factors Unsupportive Partner None

Please specify if you marked any of the above items:_____

How long has your weight been an issue? _____
What is your ideal weight?_____What is your heaviest weight? _____
Are you currently at your heaviest weight? Yes No If Yes, for how long?_____

What is motivating you to seek this type of intervention for weight loss? _____
_____
Height: _____ Current Weight: _____ Desired Weight:_____
Do you use a home scale:_____ How often do you weight yourself: _____
Are you exercise regularly: _____ How much water do you drink in a 24-hour period: _____
Typical Diet: _____

Family History

Obesity - Yes / No Diabetes – Yes / No Hypertension – Yes / No
Cancer – Yes / No Thyroid – Yes / No CAD – Yes / No
Other: _____

Personal Medical History

Do you have or have you ever had any of the following?
Depression – Yes / No Panic Attacks – Yes / No Anxiety – Yes / No
Bipolar Disease – Yes / No OCD – Yes / No Eating Disorder – Yes / No

Medications:

Do you have a history of suicide attempt or suicidal ideation: Yes / No

Cardiovascular

High Blood Pressure – Yes / No Heart Attack – Yes / No Stents – Yes / No
Pacemaker – Yes / No

Endocrine

Diabetes – Yes / No Do you have low sugar episodes – Yes / No
If yes, are you taking medication?
Thyroid Problems? – Yes / No , If yes, explain _____

Gastrointestinal

Heartburn – Yes / No Constipation – Yes / No Diarrhea – Yes / No
Do you get pain in the upper abdomen after eating? Yes / No
Have you ever been told you have gallstones? Yes / No
Have you ever had problems with your kidneys? Yes / No
Have you ever been told you have a fatty liver? Yes / No
Have you ever been diagnosed with pancreatitis? Yes / No

Respiratory

Do you have asthma? – Yes / No
Do you have CODP / Emphysema? – Yes / No
How far can you walk before get short of breath? _____

Musculoskeletal

Do you have joint pain? – Yes / No
If so, where: _____
Are you pregnant, planning to get pregnant or breastfeeding: – Yes / No
Are you taking any of the following medications:

Insulin	Tolbutamide	Ozempic	Lyburide	Adlyxin
Rybelsus	Glipizide	Byetta	Trulicity	Glimeprizide
Sydureon	Victoza	Wegovy		

List any medications you are currently taking: _____
List any medication allergies you have: _____

Date of last set of labs: _____
HbA1C: _____
Creatine: _____

Prescribers Notes Only:

_____
_____
_____

Dosage will increase every four weeks if patient still has food cravings.

Starting Dosage:

Semaglutide:	*0.25mg*	*Tirzepatide:*	*2.5mg*
	0.50mg		*3.5mg*
	0.75mg		*5.0mg*
	1.0 mg		*7.5mg*
	1.5mg		*10mg*
	2.0mg		
	2.5mg		

Prescriber Name: _____ *Signature:* _____

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the practitioner or other health professional of my current medical health conditions and to update this history. A current medical history is essential for the practitioner to execute appropriate treatment procedures, I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Client Name: _____

Client Signature:_____Date:_____