INTEGRATED HEALTH INTAKE QUESTIONNAIRE

PLEASE BRING IN THE LAST SET OF COMPLETE LABS TO YOUR INITIAL APPOINTMENT ALONG WITH THIS FORM.

PLEASE GO TO TRUTHABOUTWEIGHT.COM and OBESITYACTION.ORG PRIOR TO YOUR INITIAL CONSULT TO UNDERSTAND THE SCIENCE BEHIND WEIGHT

Name: _____ **Date of Birth:** _____/_____/_____

Primary Care physician: *(blank if none)* _____

Referring physician: *(blank if none)* _____

Please list all other healthcare providers you see and what you see them for:

_____ for _____

_____ for _____

_____ for _____

_____ for _____

ORTHO HISTORY

Are you currently experiencing pain? YES / NO

If YES, describe where and what makes the symptoms better or worse.

_____

Please rate your pain from 1 to 10 *(1 being no pain, 10 being the worse pain imaginable)*: _____

What do you do to manage your pain? _____

WEIGHT HISTORY

At what age did you first start to have a weight problem? _____

Weight at age 21: _____ **Highest Weight:** _____ **Current Weight:** _____

Has weight come on: □ GRADUALLY OVER THE YEARS □ SUDDENLY OVER CERTAIN PERIODS OF TIME

What was going on at that time? _____

What behaviors and circumstances contributed to your weight gain?

_____

_____

List your previous attempts to lose weight. What specific aspects of these attempts worked for you and what didn't?

_____

_____

_____

_____

Have you ever been able to lose weight and keep it off, or do you typically regain your weight after losing it?

_____

_____

Fill in the information below for any weight loss medications you have used in the past.

Drug Name	How long did you take it?	Was it effective?	Side Effects?
Phentermine			
Qsymia			
Saxenda			
Belviq			
Contrave			
Other:			

List any bariatric procedures you have had in the past (gastric sleeve, gastric bypass, lap band).

Procedure	Date	Weight Prior to Procedure	Lowest Weight After Procedure

EATING PATTERNS

Do you struggle with cravings? YES / NO **Do you struggle with feelings of fullness?** YES / NO

Is there a time of day when it is more difficult to avoid overeating or to avoid *less optimal* food choices? YES / NO

If YES, when? _____

Is food volume a problem? YES / NO **Do you go back for seconds?** YES / NO **Are your portions large?** YES / NO

Who cooks most in your household? _____ **Who grocery shops in your household**? _____

PSYCHO-SOCIAL HISTORY

Do you ever eat more than what most people would consume in short period of time? SOMETIMES / OFTEN / NO

Do you feel out of control when you do so? SOMETIMES / OFTEN / NO

Do you eat food in secret or hide the fact that you're eating? SOMETIMES / OFTEN / NO

Do you use vomiting, laxatives, diuretics or excessive exercise to compensate for overeating? SOMETIMES/OFTEN/NO

Are there any current barriers or challenges to following a weight reduction program? YES / NO

If "YES", explain: _____

MEDICAL QUESTIONS:

History of pancreatitis? YES / NO / UNSURE

History of seizures? YES / NO / UNSURE

History of liver disease? YES / NO / UNSURE

History of gout? YES / NO / UNSURE

If YES, when was last flare: _____

Are you on medication for gout? YES / NO

Currently taking any narcotics for pain control? YES / NO

History of kidney stones? YES / NO / UNSURE

History of kidney disease? YES / NO / UNSURE

History of Glaucoma? YES / NO / UNSURE

Personal or family history of medullary thyroid cancer? YES / NO / UNSURE

FEMALES ONLY – Is there any chance of pregnancy? YES / NO / UNSURE

Pregnancy prevention method (birth control, tubal ligation etc…)_____

FAMILY HISTORY

Do you know your family history? YES / NO / ADOPTED

Check all that apply to your IMMEDIATE FAMILY *(mom/dad/siblings/kids)***:**

- □ Heart attack
- □ Diabetes
- □ High blood pressure
- □ High cholesterol
- □ Stroke
- □ Gout
- □ Polycystic Ovarian Disease
- □ Obesity/weight issues

Please circle any major life stressors in the last 12 months:

- □ Serious injury
- □ Death of close friend/family member
- □ Divorce/Separation
- □ Other_____
- □ Gain of new family member
- □ Major illness in the family
- □ Job change

How good of a time is this for you to be starting a weight reduction program? *Circle a number*

0-----1-----2------3-----4------5------6------7-----8-----9-----10

0 = Worst time - "I can't handle one more thing at this time." 10 = Best time - "I'm ready to go for it!"

Is there one thing that you could do that would make a large difference in your weight situation? YES / NO

If "YES", What is it? _____

Why do you think you don't make that change? _____

_____

What do you foresee as my role in helping you in your efforts to lose and maintain your weight?

_____

_____

What is currently motivating you to lose weight? _____

_____

CURRENT MEDICATIONS

Write the drug name *(or bring a list)*, the dose and frequency. If you are unsure, copy the information from the bottle.

List any PRESCRIPTION MEDICATIONS that you take on a REGULAR or DAILY basis.

PRESCRIPTION MEDICATIONS	DOSE	FREQUENCY

List any PRESCRIPTION MEDICATIONS that you take AS NEEDED or INFREQUENTLY

PRESCRIPTION MEDICATIONS	DOSE	FREQUENCY

PERSONAL MEDICAL HISTORY

Check any conditions you currently have or that you had in the past.

Now	Past	Condition
☐	☐	Heart attack / Angina
☐	☐	PTCA *(Percutaneous transluminal coronary angioplasty)*
☐	☐	CABG *(Coronary artery bypass graft)*
☐	☐	Stent placement
☐	☐	High cholesterol/triglycerides
☐	☐	High blood pressure
☐	☐	Stroke
☐	☐	Diabetes
☐	☐	Pre-Diabetes
☐	☐	Gout
☐	☐	Heartburn
☐	☐	Gastro-esophageal reflux
☐	☐	Constipation
☐	☐	Irritable bowel syndrome
☐	☐	Headaches
☐	☐	Migraines
☐	☐	Overactive thyroid
☐	☐	Underactive thyroid
☐	☐	Osteoarthritis
☐	☐	Rheumatoid arthritis
☐	☐	Other joint problem
☐	☐	Fibromyalgia
☐	☐	Restless leg syndrome
☐	☐	Epilepsy
☐	☐	Cancer
		Type: _____
☐	☐	Gallstones/Gallbladder Problems

Now	Past	Condition
☐	☐	Obstructive sleep apnea
☐	☐	Insomnia
☐	☐	Depression
☐	☐	Bipolar disorder
☐	☐	Anxiety disorder
☐	☐	Personality disorder
		Type_____
☐	☐	ADD/ ADHD
☐	☐	OCD *(Obsessive Compulsive Disorder)*
☐	☐	PTSD *(Post Traumatic Stress Disorder)*
☐	☐	Emotional abuse
☐	☐	Physical abuse
☐	☐	Sexual abuse
☐	☐	Alcoholism
☐	☐	Drug addiction
		Have you been treated for any of the above?
		When _____
		Whom _____
		Medications _____
		WOMEN ONLY
☐	☐	Polycystic ovary disease
☐	☐	Fertility problems
☐	☐	Excessive facial/body hair
☐	☐	Significant acne
☐	☐	Significant PMS
☐	☐	Infrequent/irregular periods
☐	☐	Diabetes or high blood pressure