Intake Form

INTAKE FORM

WEIGHT HISTORY

- **At what age did you first start having 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?**
  _____
  _____

Fill in 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			
Phentermine/ Topiramate XR			
Liraglutide 3mg			
Naltrexone/ Bupropion XL			
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

Do you take your bariatric vitamins daily (if applicable?) Yes No

Have you had your yearly bariatric vitamin labs drawn (if applicable) Yes No

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**? _____

Food Recall

- Which meals do you eat nearly every day? **Give times and typical contents of each meal.**
- □ Breakfast
  _____
- □ Mid- Morning Snack_____
- □ Lunch
  _____
- □ Mid- Afternoon Snack
  _____
- □ Dinner
  _____
- □ Evening Snack
  _____

Psychosocial

- **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
- **Do you have a trigger weight? This would be a weight at which you start to get nervous at because of unwanted attention.** YES/NO.
  - If yes, what is that weight? _____

Pertinent Medical Hx

- **History of pancreatitis?** YES / NO / UNSURE
- **Currently taking any narcotics for pain control?** YES / NO
- **History of seizures?** YES / NO / UNSURE
- **History of kidney stones?** YES / NO / UNSURE
- **History of liver disease?** YES / NO / UNSURE
- **History of kidney disease?** YES / NO / UNSURE
- **History of gout?** YES / NO / UNSURE
- **History of Glaucoma?** YES / NO / UNSURE
- **If YES, when was last flare: _____**
- **Are you on medication for gout?** YES / NO
- **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…)*_____**

Check All that Apply for your Family History (if known)

Heart attack
Diabetes
High blood pressure
High cholesterol
Other _____

Stroke
Gout
Polycystic Ovarian Disease
Obesity/weight issues
Family hx unknown

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**

Readiness For Change

- Change your daily physical activity habits
- Would resist this 0-----1-----2------3-----4------5------6------7-----8-----9-----10 very willing to do
- Adjust your schedule
- Would resist this 0-----1-----2------3-----4------5------6------7-----8-----9-----10 very willing to do
- Log food intake
- Would resist this 0-----1-----2------3-----4------5------6------7-----8-----9-----10 very willing to do
- Engage in behavioral changes
- Would resist this 0-----1-----2------3-----4------5------6------7-----8-----9-----10 very willing to do
- Take medication to help support my journey if clinically appropriate
- Would resist this 0-----1-----2------3-----4------5------6------7-----8-----9-----10 very willing to do

Readiness For Change

Circle the level that fits:

- How concerned are you with your current weight and impact on health and quality of life?

Not serious at all 0-----1-----2------3-----4------5------6------7-----8-----9-----10 Very serious

- Currently, how important is it for you to have help to mange your weight and create a long term, sustainable management plan?

Not Important 0-----1-----2------3-----4------5------6------7-----8-----9-----10 Most important issue

- I want to improve my health and focus on reduction of weight and how to maintain it long term

Not Important 0-----1-----2------3-----4------5------6------7-----8-----9-----10 Most important issue

If it means you will improve your health, reduce weight and help you to maintain those improvements long term, how willing are you to:

- Change your eating habits
- Would resist this 0-----1-----2------3-----4------5------6------7-----8-----9-----10 very willing to do

Readiness for Change

- Do you want your weight reduction and long-term management to be part of a larger shift to a healthier overall lifestyle for you (and your family)? □ Yes □ No

- How good of a time is this for you to be working with me as your health care provider on creating a long-term comprehensive plan with you to help manage your weight and health goals long term ? *Circle a number*

Way too much going on 0--1--2--3--4---5---6--7--8--9--10 Can I see you tomorrow?

Intake Form

- **Is there one thing that you could do that would make a large difference in helping you to manage your weight long term?** 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 reduce and maintain your weight long term with an individualized and sustainable long-term plan?**
- _____ _____- _____
- **What is motivating you currently to focus on management of your weight?** _____
- _____