**Wellness & Weight Loss**

DATE ______________________

PERSONAL INFORMATION _____ Dr. _____ Mr. _____ Mrs. _____ Ms. _____ Miss

Name ______________________________________________

Address ______________________________________________

City, State, Zip ______________________________________________

Telephone (Home) ____________________ (Mobile) ____________________ Carrier ____________________

Date of Birth ______________ Age __________ Height ____________ Email ____________________

Occupation ______________________________ Spouse Occupation ______________________________

Employed By ______________________________________________

How were you referred to our office? ______________________________________________

Have you had surgery in the past? ____________ If Yes, please list ______________________________

Are you taking any medications? ____________ If Yes, please list ______________________________

______________________________________________

Are you pregnant? __________ How many children? __________ Are you Breast Feeding? __________

How much water do you typically drink in a day? ______________________________

**MEDICAL HISTORY**

Do you or any family member have/had any of the following? Please put an "x" for you, and "f" if family member

| | | |
|---|---|---|
| ______ Depression | ______ Epilepsy | ______ Headache |
| ______ Heart Attack | ______ Hypoglycemia | ______ Neck Pain |
| ______ Diabetes | ______ Anemia | ______ Poor Sleep |
| ______ Thyroid Disease | ______ Cancer | ______ Dizziness |
| ______ Gallbladder Disease | ______ High Blood Pressure | ______ Arthritis |
| ______ Kidney Disease | ______ Intestine Problems | ______ Mid Back Pain |
| ______ Stroke | ______ Shortness of Breath | ______ Low Back Pain |
| ______ Gout | ______ High Cholesterol | ______ Carpal Tunnel |

Your Primary Care Physician and full address: ______________________________________________

______________________________________________

**HISTORY**

How long have you been overweight? ______________________________________________

Have you tried to lose the weight in the past? ______________________________________________

What are your top 2 reasons why you want to lose weight? ______________________________

______________________________________________

______________________________________________

Has your doctor recommended you to lose weight? ______________________________

Can you attribute the gain to anything? ______________________________

**GOALS**

What is your Goal Weight? ______________________________

When was the last time you were at that weight? ______________________________

How much weight have you lost and gained then lost and gained in the past? ____________________

On a scale of 1-10, with 10 meaning – I'm fully committed, I want to start right now, and 1 meaning, not interested – What is your current level of commitment? ______________________________