New Patient Questionnaire (Health Care Analysis)

Today's Date: ________________________

First Name:	**Last Name:**	**Email:**		
________________	________________	________________________________		
Address:		**City:**	**State:**	**Zip Code:**
________________________________		________________	________	________
Home Phone:	**Work Phone:**	**Cell Phone:**	**Date of Birth:**	
________________	________________	________________	________________	
Age:	**Height:**	**Weight:**	**Gender:**	
________________	________________	________________	☐ **Male** ☐ **Female**	
How did you hear about us?:		**If referred by someone, who?:**		
________________________________		________________________________		

Please answer the following questions honestly so we can do our best to help you reach your goals

Who encouraged you to lose weight?: ____

How important to you is it to lose weight?: ____

What important reason, special occasion, or goal date do you have to lose weight?: ________________________

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How many pounds would you like to lose?: ___________ How fast do you want lose the weight?: _____________

Would you commit to one visit a week?: ☐ Yes ☐ No

Have you ever attended any other weight reduction centers, if so, which ones?: ________________________

What kinds of diets have you tried on your own?: ____

What is the longest you have been able to stick with a diet?: ________________________________

Does your family support your weight loss efforts?: ☐ Yes ☐ No

Have you been advised by your family physician to lose weight?: ☐ Yes ☐ No

If you answered Yes, what is your doctor's name?: ____

Do you eat because of emotions?: ☐ Yes ☐ No

If you answered yes, please explain: ____

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On average, which of the following reflects your daily eating habits? (Please check all that apply):

- ☐ 3 meals with healthy snacks
- ☐ 3 meals
- ☐ 2 meals or less
- ☐ Skip breakfast or other meals
- ☐ Generally eat on the run
- ☐ No regular eating pattern
- ☐ Often crave sweets/carbs
- ☐ Graze; small, frequent meals (How many per day? ______)

Current level of exercise (Please check one that applies):

- ☐ None
- ☐ Light exercise (1-3 times per week, easy pace, stretching, walking, etc.)
- ☐ Moderate exercise (2-3 times per week, moderate pace, some weights, etc.)
- ☐ Heavy exercise: (3-4 times per week, vigorous pace, weights, fast running, etc.)

Health Information

Past or Present Health Conditions (Please check all that apply):

- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Strokes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Hormone Imbalance
- ☐ Thyroid Imbalance
- ☐ Anorexia
- ☐ Bulimia
- ☐ Drug Addiction
- ☐ Currently pregnant or nursing
- ☐ Allergic to sulfur, food or medication

If you checked any of the above, please explain: ____

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Have you ever been hospitalized, under medical care, or checked into rehab for alcohol or drug treatment?:

☐ Yes ☐ No

If you answered yes, please explain: ____

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Please list all medications you are currently taking, including doses and reasons for taking

Medication:	Dose:	How often:	Reason:	Prescribing M.D.

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Food and Chemical Sensitivity

Please complete the following survey using the key below

☑ ☐ ☐ ☐ = No symptoms (0 points)
☐ ☑ ☐ ☐ = Mild symptoms (1 point)
☐ ☐ ☑ ☐ = Moderate symptoms (2 points)
☐ ☐ ☐ ☑ = Severe symptoms (3 points)

Weight:

- ☐ ☐ ☐ ☐ Inability to lose weight
- ☐ ☐ ☐ ☐ Food cravings
- ☐ ☐ ☐ ☐ Binge eating
- ☐ ☐ ☐ ☐ Nausea or vomiting
- ☐ ☐ ☐ ☐ Water retention

Digestive Symptoms:

- ☐ ☐ ☐ ☐ Stomach pains or cramping
- ☐ ☐ ☐ ☐ Constipation
- ☐ ☐ ☐ ☐ Diarrhea
- ☐ ☐ ☐ ☐ Reflux or heartburn
- ☐ ☐ ☐ ☐ Bloating
- ☐ ☐ ☐ ☐ Gas

Head and Ears:

- ☐ ☐ ☐ ☐ Migraines
- ☐ ☐ ☐ ☐ Headaches
- ☐ ☐ ☐ ☐ Earaches
- ☐ ☐ ☐ ☐ Wheezing
- ☐ ☐ ☐ ☐ Ear infection
- ☐ ☐ ☐ ☐ Ringing in ears

Eyes and Throat:

- ☐ ☐ ☐ ☐ Itchy eyes
- ☐ ☐ ☐ ☐ Watery eyes
- ☐ ☐ ☐ ☐ Sore throat
- ☐ ☐ ☐ ☐ Persistent canker sores

Sinus and Respiratory:

- ☐ ☐ ☐ ☐ Stuffy or runny nose
- ☐ ☐ ☐ ☐ Asthma
- ☐ ☐ ☐ ☐ Chest congestion
- ☐ ☐ ☐ ☐ Chronic cough
- ☐ ☐ ☐ ☐ Frequent sneezing

Skin Disorders:

- ☐ ☐ ☐ ☐ Dermatitis
- ☐ ☐ ☐ ☐ Excessive sweating
- ☐ ☐ ☐ ☐ Rashes
- ☐ ☐ ☐ ☐ Hives
- ☐ ☐ ☐ ☐ Eczema

Emotional and Mental:

- ☐ ☐ ☐ ☐ Depression
- ☐ ☐ ☐ ☐ Anxiety
- ☐ ☐ ☐ ☐ Mood swings
- ☐ ☐ ☐ ☐ Irritability
- ☐ ☐ ☐ ☐ Poor concentration

Energy:

- ☐ ☐ ☐ ☐ Fatigue
- ☐ ☐ ☐ ☐ Lethargy
- ☐ ☐ ☐ ☐ Restlessness
- ☐ ☐ ☐ ☐ Insomnia
- ☐ ☐ ☐ ☐ Hyperactivity

Other Symptoms:

- ☐ ☐ ☐ ☐ Joint pain
- ☐ ☐ ☐ ☐ Arthritis
- ☐ ☐ ☐ ☐ Irregular heartbeat
- ☐ ☐ ☐ ☐ Chest pains
- ☐ ☐ ☐ ☐ Muscle aches

OFFICE USE ONLY
Total Points: ____

Please list any symptoms you experience that were not previously mentioned: _______________________________________

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What is most important to you in deciding to use our services? (Please check all that apply):

- ☐ Effectiveness “My results are my top priority.”
- ☐ Time “I want results quickly.”
- ☐ Service “I need extra support along the way.”
- ☐ Ease “I have a difficult time losing weight.”

I understand that my patient file will be kept completely confidential unless I give written permission for my information to be released.

Signature: ______________________________ **Date:** ____________________

Notes:

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