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?: _____

_____

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: _____

_____

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: _____

_____

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: _____

_____

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

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

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

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Total Points: _____

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

_____

_____

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: