



## WEIGHT LOSS PROGRAM INTAKE QUESTIONNAIRE

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Hm Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Wk Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Female  Male

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

| <b>TO BE COMPLETED BY STAFF:</b> |                  |                 |
|----------------------------------|------------------|-----------------|
| Age:                             | Height (inches): | Temp:           |
| Actual Body Wt:                  | Waist (inches):  | Blood Pressure: |
| Ideal Body Wt:                   | Hips (inches):   | Pulse:          |
| Excess Body Wt:                  | BMI:             | Resp. Rate:     |
| Target Body Wt:                  | Waist:Hip Ratio: |                 |

## PATIENT HISTORY QUESTIONNAIRE

The information requested in the questionnaire is very important. To give you the best care, we must have complete answers. Please be thorough.

### WEIGHT HISTORY

Please estimate as closely as possible for all that apply.

| <b>Life Event</b>       | <b>Age</b> | <b>Weight</b> |
|-------------------------|------------|---------------|
| Birth Weight:           |            |               |
| Start of High School:   |            |               |
| High School Graduation: |            |               |
| Marriage:               |            |               |
| 1 year ago:             |            |               |
| 3 years ago:            |            |               |
| 5 years ago:            |            |               |
| 10 years ago:           |            |               |

1. Adult lowest weight (after age of 18): \_\_\_\_\_ pounds
2. Adult highest weight (after age of 18): \_\_\_\_\_ pounds

### PATIENT-REPORTED DIET ISSUES:

**Grazer:** (Do you “pick” throughout the day? Do you seem to be “always eating something”?)

yes  no  Please Describe: \_\_\_\_\_

**Night-eater:** (Do you routinely eat after dinner, before bed, in the middle of the night?)

yes  no  Please Describe: \_\_\_\_\_

**Binge-eater:** (Eat large quantities at one time: Ex: a whole bag of chips, container of ice cream, breads, pasta?)

yes  no  Please Describe: \_\_\_\_\_

**Voluntary overeating:** (Do you eat large portions?)

yes  no  Please Describe: \_\_\_\_\_

**Dietary fat intake:** (Is your diet high in fat? Ex: fried foods, fast foods, cakes, cookies, chips, “junk food”?)

yes  no  Please Describe: \_\_\_\_\_

**Socioeconomic factors:** (Do you feel your income limits you to the types of foods you purchase?)

yes  no  Please Describe: \_\_\_\_\_

**Psychosocial factors:** (“Emotional eater”-Do you eat because you’re stressed, bored, depressed, angry, etc?)

yes  no  Please Describe: \_\_\_\_\_

**Genetic disorders/factors:** (Do you have any genetic disorders or family history that contributes to obesity?)

yes  no  Please Describe: \_\_\_\_\_

**Sedentary lifestyle:** (Are you physically inactive? Has inactivity contributed to weight gain?)

yes  no  Please Describe: \_\_\_\_\_

**Ethnic factors:** (Has your family background / cultural food choices contributed to weight gain?)

yes  no  Please Describe: \_\_\_\_\_

**Medication-induced:** (Have any medications caused you to gain weight?)

yes  no  Please Describe: \_\_\_\_\_

**DIETARY HISTORY:**

Please indicate the following methods of weight loss that you have attempted.

| <b>Program</b>                             | <b>Dates</b> | <b>Duration</b> | <b>Pounds Lost</b> |
|--|--------------|-----------------|--------------------|
| <input type="checkbox"/> Jenny Craig       |              |                 |                    |
| <input type="checkbox"/> Weight Watchers   |              |                 |                    |
| <input type="checkbox"/> Nutri-System      |              |                 |                    |
| <input type="checkbox"/> LA Weight Loss    |              |                 |                    |
| <input type="checkbox"/> Quick Weight Loss |              |                 |                    |
| <input type="checkbox"/> TOPS              |              |                 |                    |
| <input type="checkbox"/> Opti/Medi Fast    |              |                 |                    |
| <input type="checkbox"/> Other:            |              |                 |                    |

| <b>Medications</b>  | <b>Dates</b> | <b>Duration</b> | <b>Pounds Lost</b> |
|---|--------------|-----------------|--------------------|
| <input type="checkbox"/> Phentermine (Adipex/Fastin)                          |              |                 |                    |
| <input type="checkbox"/> Pondimin (fenfluramine)                              |              |                 |                    |
| <input type="checkbox"/> Redux (dexfenfluramine)                              |              |                 |                    |
| <input type="checkbox"/> Meridia  |              |                 |                    |
| <input type="checkbox"/> Xenical  |              |                 |                    |
| <input type="checkbox"/> Over the Counter: ex. Dexatrim,<br>Metabolite, _____ |              |                 |                    |

| <b>Fad Diets</b>                       | <b>Dates</b> | <b>Duration</b> | <b>Pounds Lost</b> |
|--|--------------|-----------------|--------------------|
| <input type="checkbox"/> Atkins        |              |                 |                    |
| <input type="checkbox"/> South Beach   |              |                 |                    |
| <input type="checkbox"/> Cabbage Soup  |              |                 |                    |
| <input type="checkbox"/> Grapefruit    |              |                 |                    |
| <input type="checkbox"/> Mediterranean |              |                 |                    |
| <input type="checkbox"/> Other:        |              |                 |                    |

**NUTRITION HISTORY:**

- How many times a day do you eat? 1    2    3    4    5    6    7    8
- Indicate which meals / snacks you typically eat:  
 Breakfast     AM snack     Lunch     PM snack     Dinner     Evening snack

| How often do you eat the following foods? |                    | How much do you drink the following? |                  |
|---|--------------------|--------------------------------------|------------------|
| Food                                      | How Often/per week | Drink                                | How much/per day |
| Red Meat                                  |                    | Coffee                               |                  |
| Poultry                                   |                    | Tea                                  |                  |
| Fish                                      |                    | Juice                                |                  |
| Fruit                                     |                    | Soda                                 |                  |
| Vegetables                                |                    | Milk                                 |                  |
| Milk, cheese, yogurt                      |                    | Water                                |                  |
| Candies, cookies cakes                    |                    | Alcohol                              |                  |
| Other:                                    |                    | Other:                               |                  |

**What are your favorite foods?:** (Please provide as complete of a list as possible.)

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**What foods do you absolutely not like?:**

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Describe your eating pattern for the last 3 days:

|           | Day 1 | Day 2 | Day 3 |
|-----------|-------|-------|-------|
| Breakfast |       |       |       |
| Lunch     |       |       |       |
| Dinner    |       |       |       |
| Snacks    |       |       |       |
| Beverages |       |       |       |
| Other     |       |       |       |

**EXERCISE HISTORY**

How physically active are you?  Very Active  Active  Average  Inactive  Sedentary  
 Other: \_\_\_\_\_

What do you do for physical activity and how often do you do it?

| <b>Activity</b>                            | <b>Number of Times / Week</b> | <b>How Long</b> |
|--|-------------------------------|-----------------|
| <input type="checkbox"/> Walking           |                               |                 |
| <input type="checkbox"/> Bicycling         |                               |                 |
| <input type="checkbox"/> Jogging           |                               |                 |
| <input type="checkbox"/> Swimming          |                               |                 |
| <input type="checkbox"/> Water exercises   |                               |                 |
| <input type="checkbox"/> Golfing - walking |                               |                 |
| <input type="checkbox"/> Golfing - cart    |                               |                 |
| <input type="checkbox"/> Tennis            |                               |                 |
| <input type="checkbox"/> Aerobic           |                               |                 |
| <input type="checkbox"/> Weight training   |                               |                 |
| <input type="checkbox"/> Spin cycling      |                               |                 |
| <input type="checkbox"/> Other             |                               |                 |

Which exercise activities do you enjoy the most? \_\_\_\_\_

Which exercise activities do you dislike the most? \_\_\_\_\_

How long have you been engaged in your current regimen? \_\_\_\_\_  
\_\_\_\_\_

Is there anything that prevents you from being physically active? \_\_\_\_\_  
\_\_\_\_\_

How committed are you to incorporating physical activity into your lifestyle?  
Rate from 1 (not committed) to 10 (it will happen without a doubt). \_\_\_\_\_

**MEDICAL HISTORY:**

Please list all medications you are currently taking:

| Medication   | Dose and Frequency |
|--|--------------------|
|  |                    |
|  |                    |
|  |                    |
|  |                    |
|  |                    |
| Allergic to any medications: <input type="checkbox"/> no <input type="checkbox"/> yes: |                    |

| Illness (past or current)                               | No | Yes (Explain) |
|---|----|---------------|
| Heart Disease (murmurs, palpitations, chest pain, etc.) |    |               |
| High Blood Pressure                                     |    |               |
| Breathing Problems (asthma / emphysema)                 |    |               |
| Diabetes  |    |               |
| Thyroid Problems  |    |               |
| High Cholesterol  |    |               |
| Sleeping Problems (insomnia / sleep apnea, snoring)     |    |               |
| Depression  |    |               |
| Eating Disorder (Anorexia/Bulimia)                      |    |               |

| Major Surgeries | Approximate Date |
|-----------------|------------------|
|                 |                  |
|                 |                  |
|                 |                  |
|                 |                  |

Do you currently use tobacco: no yes: \_\_\_\_ packs per day; \_\_\_\_ years

Do you currently use alcohol: no  yes: \_\_\_\_ drinks per day;  beer  wine  liquor

Do you currently use:  marijuana  cocaine  heroin  amphetamine  other\_\_\_\_\_

**FAMILY HISTORY:**

Obesity: \_\_\_\_\_  high cholesterol: \_\_\_\_\_

Heart Disease: \_\_\_\_\_  Other: \_\_\_\_\_

Lung Disease: \_\_\_\_\_

## Disclosure / Liability Waiver

Bay Area Laser Skin Care & Wellness Center - Weight Loss Program follows guidelines set forth by the American Heart Association, National Institutes of Health, and the National Heart, Lung, and Blood Institutes. While numerous safety measures are taken by our physicians and staff, incidental events may occur that is beyond the control our staff. It is therefore expressly agreed that all dietary and exercise regimens, and the use of any medications and/or supplements is undertaken at the weight loss client's own risk. You are voluntarily participating in this program and assume all the risks of injury to yourself that might result. You hereby agree to waive any claims or rights you might otherwise have to pursue legal remedies from Bay Area Laser Skin Care & Wellness Center or its staff for injury to you on account of involvement in the Weight Loss Program. You have carefully read this waiver and fully understand that it is a release of liability.

I accept all terms and conditions of this offer.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date