Weight Loss Intake Form

Current height:_____ Current weight:_____

Medical History

Surgeries:_____Allergies:_____
Hypothyroidism (please circle): Yes/No Insulin Resistance: Yes/No Depression Yes/No
Eating disorders: Yes/No
Current Medication list:_____
Antidepressants: Yes/No. Antipsychotics: Yes/No Steroids: Yes/No. Beta-Blockers: Yes/No
Antihistamine: Yes/No Birth Control: Yes/No
Physical Limitations:_____

Dietary Habits

Typical daily food intake- Breakfast:_____
Lunch:_____
Dinner:_____

Previous attempts at weight loss:_____
Previous diets:_____
Previous weight loss medications:_____

Lifestyle

Level of physical activity (please circle): Gentle / Moderate / Vigorous

Occupation:_____ Sleep habits:_____

Stress levels (please circle): Low (1-3) / Moderate (4-7) / High (8-10)

Sleep problems (please circle): None / Some nights / Most nights

Alcohol use: Yes/No Tobacco use: Yes/No Caffeine use: Yes/No

Expectations

What is your reason for seeking weight loss:

_____

_____

_____

Weight Loss Goals

1._____

2._____

3._____

- Have you or a family member ever had thyroid cancer: Yes/No
- Have you or a family member ever been diagnosed with Multiple Endocrine Neoplasia Syndrome type 2 (MEN)? Yes/No
- Have you every had a personal history of pancreatitis: Yes/No
- Are you pregnant or planning on becoming pregnant: Yes/No Are you breastfeeding: Yes/ No
- Do you have Type I diabetes? Yes/ No Have you ever had suicidal ideation? Yes/No

Patient Name:_____Chart #:_____