

INITIAL PATIENT QUESTIONNAIRE

NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE (\_\_\_\_) \_\_\_\_\_  
CELL PHONE (\_\_\_\_) \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_ SEX \_\_\_\_  
SOCIAL SECURITY # \_\_\_\_\_  
EMAIL ADDRESS \_\_\_\_\_

PRIMARY INSURANCE \_\_\_\_\_  
INSURANCE ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
INSURANCE PHONE: (\_\_\_\_) \_\_\_\_\_  
POLICY HOLDER: \_\_\_\_\_  
POLICY # \_\_\_\_\_ GROUP# \_\_\_\_\_

OCCUPATION \_\_\_\_\_  
EMPLOYER \_\_\_\_\_  
EMPLOYER ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
EMPLOYER'S PHONE (\_\_\_\_) \_\_\_\_\_

SECONDARY INSURANCE \_\_\_\_\_  
INSURANCE ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
INSURANCE PHONE (\_\_\_\_) \_\_\_\_\_  
POLICY HOLDER \_\_\_\_\_  
POLICY# \_\_\_\_\_ GROUP# \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_  
SOCIAL SECURITY # \_\_\_\_\_  
SPOUSE'S EMPLOYER \_\_\_\_\_  
EMPLOYER'S PHONE \_\_\_\_\_

RACE:  
CAUCASION \_\_\_\_ AFRICIAN AMERICAN \_\_\_\_  
HISPANIC OR LATINO \_\_\_\_ OTHER \_\_\_\_\_

SINGLE \_\_\_\_ MARRIED \_\_\_\_ DIVORCED \_\_\_\_  
WIDOWED \_\_\_\_ SEPARATED \_\_\_\_ OTHER \_\_\_\_

DRIVER'S LICENSE# \_\_\_\_\_  
STATE \_\_\_\_\_ EXPIRATION \_\_\_\_\_

(PRIMARY CARE PHYSICIAN) \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
PHONE (\_\_\_\_) \_\_\_\_\_

REFERRING PHYSICIAN \_\_\_\_\_  
PHYSICIAN ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
PHONE (\_\_\_\_) \_\_\_\_\_

WHY ARE WE SEEING YOU TODAY? \_\_\_\_\_

WHO IS THE CLOSEST RELATIVE NOT LIVING WITH YOU? \_\_\_\_\_  
RELATIONSHIP? \_\_\_\_\_ PHONE \_\_\_\_\_

MEDICARE SIGNATURE AUTHORIZATION

I authorize any holder of medical or other information about me to be released to the social security administration and health care financing administration or its intermediaries or carriers or to the billing agent of this physician or supplier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand that this signature is a lifetime signature.

Signature

Date

AUTHORIZATION AND ASSIGNMENT

I assign to the undersigned Physician all payments for services rendered and authorize payment made directly to him. I also authorize the Physician to furnish information to insurance carriers concerning my illnesses and my treatments.

Signature

Date

**PRESENT MEDICAL HISTORY**

NAME: \_\_\_\_\_ DATE \_\_\_\_\_  
PRIMARY CARE PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_  
HOW LONG HAVE YOU BEEN OVER-WEIGHT? \_\_\_\_\_

**PERSONAL AND FAMILY HISTORY**

PATIENT	FAMILY HISTORY (CHECK IF APPLICABLE)		
	MOTHER	FATHER	SIBLING
1. HEART DISEASE, ANGINA, CHEST PAIN	YES ___ NO ___ DATE _____	_____	_____
2. HYPERTENSION	YES ___ NO ___ DATE _____	_____	_____
3. STROKE	YES ___ NO ___ DATE _____	_____	_____
4. DIABETES	YES ___ NO ___ DATE _____	_____	_____
5. CANCER _____	YES ___ NO ___ DATE _____	_____	_____
6. KIDNEY DISEASE	YES ___ NO ___ DATE _____	_____	_____
7. LIVER DISEASE (HEPATITIS)	YES ___ NO ___ DATE _____	_____	_____
8. STOMACH OR BOWEL DISORDER	YES ___ NO ___ DATE _____	_____	_____
9. HERNIA _____	YES ___ NO ___ DATE _____	_____	_____
10. VARICOSE VEINS	YES ___ NO ___ DATE _____	_____	_____
11. GALLBLADDER DISEASE	YES ___ NO ___ DATE _____	_____	_____
12. ARTHRITIS _____	YES ___ NO ___ DATE _____	_____	_____
13. VASCULAR DISEASE	YES ___ NO ___ DATE _____	_____	_____
14. BACK PROBLEMS	YES ___ NO ___ DATE _____	_____	_____
15. ASTHMA	YES ___ NO ___ DATE _____	_____	_____
16. EMPHYSEMA	YES ___ NO ___ DATE _____	_____	_____
17. ANEMIA: IRON DEFICENCY OR B12	YES ___ NO ___ DATE _____	_____	_____
18. SEIZURE DISORDER	YES ___ NO ___ DATE _____	_____	_____

PLEASE EXPLAIN ALL YES CHECKS: \_\_\_\_\_  
\_\_\_\_\_

LIST ALL MEDICATIONS YOU ARE NOW TAKEN AND IN WHAT DOSES:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

LIST MONTH AND YEAR OF ALL HOSPITAL STAYS AND SURGERIES:

\_\_\_\_\_  
\_\_\_\_\_

ARE YOU ALLERGIC TO ANY MEDICATIONS? \_\_\_\_\_ YES \_\_\_\_\_ NO  
IF YES, PLEASE LIST \_\_\_\_\_

DO YOU CURRENTLY SMOKE? \_\_\_ YES \_\_\_ NO # CIGARETTES/ DAY? \_\_\_\_\_ # YEARS? \_\_\_\_\_  
DID YOU USED TO BE A SMOKER? \_\_\_\_\_ YES \_\_\_\_\_ NO # CIGARETTES/DAY? \_\_\_\_\_ # YEARS? \_\_\_\_\_  
WHEN DID YOU QUIT SMOKING? \_\_\_\_\_

DO YOU DRINK BEER/WINE/ALCOHOL? \_\_\_\_\_ YES \_\_\_\_\_ NO AMOUNT PER DAY? \_\_\_\_\_

IS YOUR CONDITION DUE TO A JOB RELATED ACCIDENT? \_\_\_\_\_ YES \_\_\_\_\_ NO  
IS YOUR VISIT THE RESULT OF AN AUTO ACCIDENT? \_\_\_\_\_ YES \_\_\_\_\_ NO  
DATE OF ACCIDENT? \_\_\_\_\_

**SIGNATURE**

**DATE**

**(FOR WOMEN ONLY)**

**IF YOU ARE STILL MENSTRUATING:**

DATE OF LAST MENSTRUAL PERIOD? \_\_\_\_\_ ARE YOUR PERIODS REGULAR? \_\_\_\_\_Y \_\_\_\_\_N  
 FLOW: LIGHT\_\_\_ MEDIUM\_\_\_ HEAVY\_\_\_ CURRENT BIRTH CONTROL METHOD? \_\_\_\_\_  
 ARE YOU CURRENTLY TRYING TO CONCEIVE? \_\_\_Y \_\_\_N POLYCYSTIC OVARIAN SYNDROME \_\_\_Y \_\_\_N  
 BREAST DISEASE \_\_\_\_\_Y \_\_\_\_\_N IF YES, PLEASE EXPLAIN \_\_\_\_\_

**WEIGHT HISTORY**

PLEASE STATE YOUR WEIGHT AT THE FOLLOWING AGES. INDICATE WHETHER ANYTHING SIGNIFICANT HAPPENED WHICH MAY CONTRIBUTE TO A WEIGHT GAIN OR A WEIGHT LOSS. (Milestone: Birth of a child, quit smoking, moved, loss of a loved one, marriage, divorce, change of job, etc.)

How long have you been 70-100 pounds overweight? \_\_\_\_\_  
 Were you overweight as a child? \_\_\_\_\_

AGE	WEIGHT	MILESTONE	AGE	WEIGHT	MILESTONE
PRESCHOOL			40		
20			45		
25			50		
30			55		
35			60		

**DIET HISTORY**

Identify weight loss programs or methods you have utilized in the past. Check methods used and appropriate dates. **Also include pounds lost and regained.**

<u>DIET</u>	<u>DATE &amp; RESULTS</u>	<u>DIET</u>	<u>DATE&amp;RESULT</u>
1. Diet Pills/over the counter _____	10. Susan Powter _____		
2. Diet Pills/prescription _____	11. Atkins/ South Beach _____		
3. Diet Shots (HCG, B-12, Diuretics) _____	12. Anti-depressants (Prozac, Paxil, Wellbutrin) _____		
4. Weight Watchers _____	13. Acupuncture _____		
5. Overeaters Anonymous _____	14. Gastric Surgery _____		
6. Nutri-Systems, Jenny Craig, Metabolic Research _____	15. Therapy/Counseling _____		
7. Opti-Fast, Medi-Fast, Liquid Protein _____	16. Nutritionist _____		
8. Hypnosis _____	17. In-patient/ Out-patient treatment _____		
9. Richard Simmons _____	18. Other (Jaw wired shut, etc.) _____		

**LIST ALL PHYSICIANS THAT PRESCRIBED MEDICATION AND/OR DIET AND MONITORED YOUR WEIGHT LOSS:**

DR. _____	MEDS/DIET _____	DATE _____
DR. _____	MEDS/DIET _____	DATE _____
DR. _____	MEDS/DIET _____	DATE _____
DR. _____	MEDS/DIET _____	DATE _____

**PLEASE FEEL FREE TO INCLUDE YOUR OWN LISTING OF ALL ATTEMPTS TO LOSE WEIGHT BUT IT IS VERY IMPORTANT TO INCLUDE DETAILS OF ANY MEDICALLY SUPERVISED WEIGHT LOSS EFFORT AND INCLUDE THE DOCUMENTATION (PROGRESS NOTES).**

Signature \_\_\_\_\_ Date \_\_\_\_\_

# 12 REASONS

## “Why I want to reach my ideal body size”

NAME \_\_\_\_\_ DATE \_\_\_\_\_

Before writing these reasons out, give some thought to them. It is of the utmost importance that these 12 reasons be true goals and desires that are very personal to you. They should not be generalizations or what you think would please US because they will be used as your “PERSONAL MOTIVATOR”. Each day before you go to sleep, slowly read through this list. This is what is called mental programming. Besides making a copy for the Doctor, also transfer this list onto a 3x5 card that is to be carried with you at ALL TIMES! When confronted with a difficult food situation, make the following commitment to yourself NOW. Regardless of whether you finally eat the food or not, you will read the entire card BEFORE doing so. Unlike your previous promises of “I’m not going to eat this,” which never worked anyway, this will be a positive resolution. It involves doing something rather than avoidance of eating a specific food.

1. \_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_\_

4. \_\_\_\_\_

\_\_\_\_\_

5. \_\_\_\_\_

\_\_\_\_\_

6. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. \_\_\_\_\_

\_\_\_\_\_

8. \_\_\_\_\_

\_\_\_\_\_

9. \_\_\_\_\_

\_\_\_\_\_

10. \_\_\_\_\_

\_\_\_\_\_

11. \_\_\_\_\_

\_\_\_\_\_

12. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_