Supplemental Health Questionnaire

SURGERIES / HOSPITALIZATIONS

Year:_____ Diagnosis / Procedure _____
Year:_____ Diagnosis / Procedure _____
Year:_____ Diagnosis / Procedure _____

FAMILY HISTORY

Have any family members been diagnosed with any health problems? *(i.e. hypertension, diabetes, cancer, heart attack, stroke, etc.)*
Mother:_____
Father:_____
Siblings:_____
Grandparents:_____
Others:_____

Do you currently suffer from:

- □ Depression
- □ Anxiety
- □ Mood swings
- □ Irritability
- □ Poor concentration
- □ Menopausal symptoms
- □ Joint pain
- □ Arthritis
- □ Irregular heartbeat
- □ Chest pains
- □ Muscle aches
- □ Fatigue
- □ Lethargy
- □ Restlessness
- □ Insomnia
- □ Hyperactivity
- □ Food cravings
- □ Binge eating
- □ Nausea or vomiting
- □ Water retention
- □ Shortness of Breath
- □ Hypoglycemia

Have you ever been diagnosed with or treated for:
Anorexia? □Yes □No Bulimia? □Yes □No Drug Addiction? □Yes □No Alcoholism? □Yes □No

Please answer all questions honestly so we can better help you reach your goal.
What is your current weight? _____ How tall are you? _____
What is your ideal weight/size? _____ How fast do you expect to lose the weight? _____
Who encouraged you to lose weight? _____
How important to you is it to lose weight? _____
Is there a special occasion or date prompting you to lose weight? _____
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 habits? *Please check all that apply*

Eating Habits

- □ 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

- □ 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.)

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

- □ Effectiveness "My results are my top priority."
- □ Ease "I have a difficult time losing weight."
- □ Service "I need extra support along the way."
- □ Convenience "I like to check in often."
- □ Time "I want results quickly."
- □ Medical Supervision "I want to lose weight in a healthy way."

I certify the above information is accurate and complete to the best of my knowledge. I understand that my patient file will be kept completely confidential unless I give written permission for my information to be released.

Patient Signature:_____ Date:_____

Name: _____ DOB: _____ _____
Reviewed/Date