SCOTT MEDICAL HEALTH CENTER, P.C.
WEIGHT LOSS CLINIC

LIFESTYLE QUESTIONNAIRE
Health Risk Analysis

Today's Date:_____/____/____ DOB:___/____/____ Age: _____ Height: ________ Weight:________

Last Name______________________________ First Name______________________ Gender: **F** **M**

Address_______________________________________City____________________State____Zip________

Email:____ Cell: (______)_______-__________

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.

What made you decide to do something about your weight today? ____________________________________

____

Who encouraged you to lose weight?_______________________ Can you commit to one visit a week? **Y** **N**

What important reason, special occasion, or goal date do you have for wanting to lose weight?______________

____

How important to you is it that you lose weight?_______________________

How many pounds would you like to lose?________ How fast do you want to be slim, trim & fit?_______________

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? **Y** **N**

Have you been advised by your family physician to lose weight? **Y** **N**

If yes, what is your doctor's name? : ____

Do you eat because of emotions? **Y** **N**

If yes, please explain:

____

____

On average, which of the following reflects your daily eating habits? **(Please check all that apply.)**

___ 3 meals with healthy snacks ____ Skip breakfast or other meals

___ 3 meals ____ Generally eat on the run

___ 2 meals or less ____ No regular eating pattern

___ Graze; small, frequent meals (*How many per day?* ______) ____ Often crave sweets/carbs

Please check your 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.

HEALTH INFORMATION

Past or Present Health Conditions:

DIABETES:	**Y** **N**	HORMONE IMBALANCE:	**Y** **N**
HYPOGLYCEMIA:	**Y** **N**	THYROID IMBALANCE:	**Y** **N**
STROKES:	**Y** **N**	ANOREXIA:	**Y** **N**
HEART DISEASE:	**Y** **N**	BULIMIA:	**Y** **N**
HIGH BLOOD PRESSURE:	**Y** **N**	DRUG ADDICTION:	**Y** **N**

ARE YOU CURRENTLY PREGNANT OR NURSING? **Y N**
ARE YOU ALLERGIC TO SULFUR, FOOD OR MEDICATION? **Y N**

If you answered YES to any of the above, please explain:

____

____

Have you ever been hospitalized, under medical care, or checked into rehab for alcohol or drug treatment? **Y N**

If YES, please explain:

____

____

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

____

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Personal Analysis: Where do you feel you are in each area, on a scale of 1 to 10?
(1 = very poor and 10 = Ideal Health)

SCORE	1	2	3	4	5	6	7	8	9	10
Physical Health										
Body Weight										
Energy Levels										
Pain Levels										
Relationship Health										
Emotional Health										

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

What is the most important element in deciding to use our services? **(Circle only one)**

- **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:*** ____________

FOR OFFICE USE ONLY

SUPPORT TEAM

FAMILY	EXTENDED FAMILY	FRIENDS

FOR OFFICE USE ONLY

Initial Weight________ Age______ Height_____________ Ideal Weight________ Must Lose______________
Treatment Weeks_________ ½ Way Point______________ Goal Date________________
Initial Body Fat %_________ BMI_______ Waist_________
Program Director_______________________________

Notes:

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