Advanced Wellness Center
Weight Loss Program – Patient Health & Wellness Assessment

General Information

Name: _____

Address: _____

City: _____ *State:* _____ *Zip:* _____

Phone: _____ *Alt. Phone:* _____

E-mail: _____ *Preferred method of contact:* _____

Date of Birth: _____ *Current Age:* _____

EMERGENCY Contact Information: NAME: _____

Relationship: _____ *Phone:* _____

Whom may we thank for referring you? _____

Personal / Social Information

On a scale of 1 – 10, please indicate what level of importance you would place on losing weight with Advanced Wellness Center's supervised weight loss program.
With 1 being the least and 10 being the most important _____

What is your marital status? *Single / Married / Divorced / Widowed*

Do you have children? _____ *If so, how many?* _____

Do you have pets? _____

What is your occupation? _____ *Hours per week?* _____

Will your family / friends be supportive of your desire to make food / lifestyle changes?

_____

Previous Dieting Experiences

Have you been on a diet or supervised weight program before? Yes / No
If yes, please specify which diet and what did or did not work for you.

What is your current weight: _____ Height: _____

What was your weight 1 year ago? _____

What was your maximum adult weight? _____ At what age? _____

What was your minimum adult weight? _____ At what age? _____

Do you exercise? Yes / No

If yes, how often and what types of exercise do you do?

If no, are there any types you have enjoyed in the past or may be interested in?

Any physical limitations that would prevent you from exercising?

_____

Do you cook at home? Yes / No

What percentage of your food is home cooked? 0% / 25% / 50% / 75% / 100%

Besides home, where are you eating most often? _____

Do you experience any cravings for sugar, coffee or cigarettes or have any major addictions?

_____

What is the number one thing you feel you should change about your diet to improve your health and weight?

Do you have a goal weight? Yes / No If yes, what is it? _____

Eating Habits *(Please be as honest as possible so that we may better help you)*

Breakfast:
Do you have breakfast every morning? *Yes* *Sometimes* *Never*
Examples:

_____
_____
_____

Snacks:
Do you have a snack before lunch? *Yes* *Sometimes* *Never*
Examples:

_____
_____

Lunch:
Do you have lunch every day? *Yes* *Sometimes* *Never*
Examples:

_____
_____
_____

Snacks:
Do you have a snack after lunch? *Yes* *Sometimes* *Never*
Examples:

_____
_____

Dinner:
Do you have dinner every day? *Yes* *Sometimes* *Never*
Examples:

_____
_____
_____

Snacks:
Do you have a snack at night? *Yes* *Sometimes* *Never*
Examples:

_____
_____
_____

Health Information

What are your main health concerns?

_____

Do you have any food allergies? Yes / No
If so, please list:

_____

Do you have any medication allergies? Yes / No
If so, please list:

_____

Any other allergies? Seasonal or environmental?

_____

Are you currently taking any medications? Yes / No
If so, please list types and doses:

_____

_____

_____

Are you interested in getting off any or all of your prescription medications? Yes / No

_____

_____

Are you currently taking any vitamins or supplements? Yes / No
If so, please list types and doses:

_____

_____

_____

Health History

Please mark a Yes or No to indicate if you have experienced any of the following:

Acid Reflux	☐*Yes* ☐*No*	*Herniated Disc*	☐*Yes* ☐*No*
AIDS / HIV	☐*Yes* ☐*No*	*Hypertension*	☐*Yes* ☐*No*
Alcoholism	☐*Yes* ☐*No*	*Hypoglycemic*	☐*Yes* ☐*No*
Allergy Shots	☐*Yes* ☐*No*	*Irritable Bowel*	☐*Yes* ☐*No*
Anemia	☐*Yes* ☐*No*	*Kidney Disease*	☐*Yes* ☐*No*
Anorexia	☐*Yes* ☐*No*	*Liver Disease*	☐*Yes* ☐*No*
Arthritis	☐*Yes* ☐*No*	*Lupus*	☐*Yes* ☐*No*
Asthma	☐*Yes* ☐*No*	*Macular Degeneration*	☐*Yes* ☐*No*
Breast Lumps	☐*Yes* ☐*No*	*Migraines*	☐*Yes* ☐*No*
Bronchitis	☐*Yes* ☐*No*	*MS*	☐*Yes* ☐*No*
Bulimia	☐*Yes* ☐*No*	*Osteoarthritis*	☐*Yes* ☐*No*
Cataracts	☐*Yes* ☐*No*	*Osteoporosis*	☐*Yes* ☐*No*
Celiac Disease	☐*Yes* ☐*No*	*Panic Attack*	☐*Yes* ☐*No*
Chronic Fatigue	☐*Yes* ☐*No*	*Parkinson's*	☐*Yes* ☐*No*
Crohn's Disease	☐*Yes* ☐*No*	*Pinched Nerve*	☐*Yes* ☐*No*
Colitis	☐*Yes* ☐*No*	*Psoriasis*	☐*Yes* ☐*No*
Constipation	☐*Yes* ☐*No*	*Psychiatric Care*	☐*Yes* ☐*No*
Depression	☐*Yes* ☐*No*	*Rheumatoid Arthritis*	☐*Yes* ☐*No*
Diarrhea	☐*Yes* ☐*No*	*Sleep Apnea*	☐*Yes* ☐*No*
Diverticulosis	☐*Yes* ☐*No*	*Stroke*	☐*Yes* ☐*No*
Fibromyalgia	☐*Yes* ☐*No*	*Thyroid Problems*	☐*Yes* ☐*No*
Gastric Ulcer	☐*Yes* ☐*No*	*Tumors, Growths*	☐*Yes* ☐*No*
Glaucoma	☐*Yes* ☐*No*		
Headaches	☐*Yes* ☐*No*		
Heartburn	☐*Yes* ☐*No*	*Cancer*	☐*Yes* ☐*No*
Heart Disease	☐*Yes* ☐*No*	*If yes, are you in remission?*	☐*Yes* ☐*No*
		Please explain _____	
Diabetes	☐*Yes* ☐*No*	_____	

If yes, which type:
_____*Type I – Insulin dependent (insulin injections only)*
_____*Type II – Non-Insulin dependent (diabetic pills)*
_____*Type II – Insulin dependent (diabetic pills & insulin)*

Women – Health History

Please indicate date of your last menstrual cycle: _____

Pregnant	☐*Yes* ☐*No*	*Heavy Periods*	☐*Yes* ☐*No*
Breast Feeding	☐*Yes* ☐*No*	*Hysterectomy*	☐*Yes* ☐*No*
Amenorrhea	☐*Yes* ☐*No*	*Irregular Periods*	☐*Yes* ☐*No*
Cancer	☐*Yes* ☐*No*	*Menopause*	☐*Yes* ☐*No*
Fibrocystic Breasts	☐*Yes* ☐*No*	*Painful Periods*	☐*Yes* ☐*No*

Health History – Continued

Do you smoke □*Yes* □*No*
If yes, how many packs per day and how long? _____

Do you drink alcohol? □*Yes* □*No*
If yes, what, how much and how often? _____

How many glasses of water do you drink each day? _____*glasses*

How many cups of coffee do you drink each day? _____*cups*

How often do you get a cold or the flu? (i.e., 1 – 2 times per year) _____

Please indicate any additional health concerns not covered in this patient form.

_____

_____

_____

Health and Wellness Coaching, Nutrition Consulting, and Weight Loss Programs focus on helping you make the changes necessary to create optimal health. These programs are not meant to replace the care of traditional physicians, psychologists or therapists. Rather, they augment the services you may already receive under their care.
It is important to note, we do not offer to diagnose or treat any disease. Dietary consultation involves a health profile whole purpose is not to establish a diagnosis, but rather to determine a client's health status in order to guide his or her weight-loss plan. A client may be advised to seek medical advice based on his or her health profile. As always, we suggest anyone with a serious medical condition consult with his or her physician or qualified medical professional before beginning any new healthcare regimen.

(Signature of Client or Responsible Party) *(Date)*

(Signature of Program Consultant) *(Date)*