HealthyOne WeightLoss
Your Personal Health Coach

Todays Date_____

Welcome to Our Office!

Name_____ DOB (MM/DD/YY) _____
Address_____
City_____ State_____ Zip_____
Telephone-Home (____) _____ Mobile (____)_____
Email_____ Age_____ HT_____ft____in WT_____ lbs
Occupation_____ Employer_____
Marital Status_____
# of Children and Ages _____
Were any delivered C-Section? _____ Are any of the children overweight?_____
How were you referred to our office? _____
Are you taking any medication? NO YES Do you wear a pacemaker? NO YES
If Yes please list_____
Are you pregnant? NO YES Are you breast feeding? NO YES

MEDICAL HISTORY

Do you or any family member have/had any of the following? Family use "F", personally use "√"

_____Heart Attack _____Diabetes* (If yes, is it under control? YES NO) _____Thyroid Disease _____Gallbladder Disease _____Kidney Disease _____Stroke _____Grave's Disease* _____Gout _____Hypoglycemia _____Anemia _____Cancer (type _____) _____High Blood Pressure* (If yes, does it require more than 2 medications? YES NO) _____Low Blood Pressure* _____Weak/Compromised Immune system*	_____High Cholesterol _____Headache _____Poor Sleep _____Arthritis _____Shortness of Breath _____Allergies _____ _____Psoriasis _____Other Skin Conditions _____Upset Stomach (chronic) Have you had Blood Work performed in past 12 mo.?_____ Any Issues or Abnormalities? _____	_____Intestinal Problems _____Depression _____Digestive Issues _____Crohn's Disease _____ Irritable Bowel (IBD) Have you taken an anti biotic in the last 12 months? _____ Type _____ How Long _____ Other Conditions: _____ _____ _____ _____ _____

Primary Care Physician name and address: _____
_____
Has your Primary Care Physician recommended you to lose weight? NO YES

HISTORY

How long have you been overweight? _____ Have you tried to lose weight in the past? NO / YES
If YES, please list programs_____
What are your top 2 reasons **WHY** you want to lose weight? _____
_____
What has **Prevented** you from losing weight in the Past? _____
_____

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Can you attribute your weight gain to anything specific?_____

Are there any other health concerns you need to share ? _____

_____

GOALS

What is your current weight? _____ What is your goal weight? _____

When was the last time you were at that weight? _____

How much have you lost and gained and then lost and gained in the past? _____

On a scale of 1-10, with 10 meaning – I'm fully committed to losing weight and getting healthy… what is your commitment level? _____

To better serve you, we would like to know more about your current lifestyle and habits. All information is confidential. Please answer the following questions to the best of your ability and as honestly as possible. Thank You.

How would you rate the FREQUENCY of your exercise?	**Never- I----------I- Daily**
How would you rate the INTENSITY of your exercise?	**Low - I----------I High**
Do you use any tobacco products?	**Daily - I----------I- Never**
How often do you consume alcoholic beverages?	**Daily - I----------I- Never**
Do you "binge" eat?	**Daily - I----------I- Never**
Do you have dessert or snack in the evenings?	**Daily - I----------I- Never**
Do you drink Soda Pop (including Diet)?	**Daily - I----------I- Never**

How many times / month do you:

Eat "Fast Food"? _____ /month **(note; 73% of Americans eat Fast Food at least 1X / week, 30% 2X or more)**

Eat at a Sit Down Restaurant? _____ /month

Visit Starbucks, Dunkin Donuts, etc.? _____ /month

Get something from a vending machine? _____/ month

After answering the above questions, How would you Rate your *Overall Health*?

☹**Extremely Poor - 0 1 2 3 4 5 6 7 8 9 10 –Absolute "Health Nut"** ☺

Our Patients typically have three concerns prior to starting our program; 1.Their Health, 2.the Cost and 3.Can They Do it. These are our concerns as well. Which is most important to you and what else would you like us to know about your weight loss struggles, if any? _____

_____

_____

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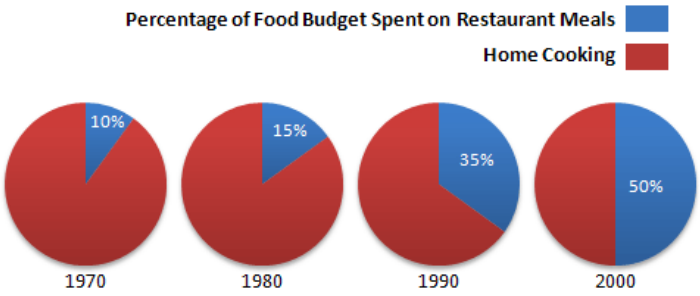
The Average American Adult (Ages 19-50) on a Moderate eating Diet spends between $63-$75 / week on groceries alone. *(US Census Bureau 2012 Abstract, Table 732, *Weekly Cost of a nutritious Diet*…)

1. What do you feel you currently spend on groceries for yourself each week. Take into consideration other household members, and the purchase of snacks, processed foods, soda pop, alcohol, etc. ? $_____ / week (self)



1. Based on the information above and what you have provided, what do you think you spend each week on Fast Food, Dining Out (including gratuity), snack machines, Donut or Coffee Shops, etc.? $_____ / week (self)

To best help you, Please take the time and let us know anything else that you feel is important and should be considered.

_____

_____

_____

_____

_____

_____ _____

Patient Signature Date

_____ _____

Doctor / WC, H1WL Signature Date

CONGRATULATIONS on taking the 1st step in changing your life!