DAY	Date	Time
DOC:		Acct#
Conf: Yes No		Staff:

ALLEGHENY MEDICAL
COMPLETE CARE. ONE PLACE.

WEIGHT LOSS INTAKE FORM

NAME: _____ Date of Birth: _____
First MI Last

ADDRESS: _____ Email: _____
Street City State Zip

Best phone number(s) to reach you: H#_____ C#_____ W#_____

How did you hear about us? _____ How much weight are you wanting to lose? _____

** Please remember to abstain from food, caffeine, and exercise for 4 hours before your 1st appointment

PROGRAMS ☐ **6 Week** ☐ **8 Week** ☐ **12 Week** ☐ **Maintenance: Injections Only**

In Case of Emergency

Contact_____ (Relationship)_____

Phone Number: H: _____ C: _____

Medical History: (please check all that apply)

☐Heart Disease	☐Kidney Disease	☐Arrhythmia	☐Liver Disease	☐Muscular Disease
☐Cancer	☐Arthritis	☐Anxiety	☐Nervous Disorder	☐Anemia
☐High Blood Pressure	☐Asthma	☐Dizziness	☐Cardiovascular Disease	☐Ulcers
☐Diabetes	☐Migraines	☐Head Injury	☐Spinal Injuries	☐Heartburn
☐High Cholesterol	☐Sleep Apnea	☐Seizures	☐Shortness of Breath	☐Frequent Headaches
☐Thyroid Disease	☐GI Disorder	☐Stroke	☐Irregular Heartbeat	☐Other

Please list all current medications/supplements:

Medications/Supplements	Doses	Frequency

Weight History

Height_____ Weight_____ Weight 1 Year Ago_____ Lowest Adult Weight_____

At what age? (Lowest weight) _____ How Long? _____

Why do you wish to lose weight at this time? _____

What is your personal goal weight at this time? _____

Has your Primary Care Physician suggested a weight loss/exercise program? Yes☐ No☐

Name of PCP: _____ Contact Number: _____

If yes, what type of treatment was recommended? Exercise☐ Diet☐ Medication☐

Have you ever had weight loss surgery? Yes☐ No☐

If yes, list approximate date_____

Have you ever had nutrition counseling? Yes☐ No☐

If yes, by whom_____

Have you ever been diagnosed with an eating disorder? ◉ Yes or ○ No

Have you participated in a previous weight loss program? If so, please complete information below:

Diet Program	Year Started	Weight Loss	Reason-Stopped	Medication/Supplements

Please check appropriate box that might contribute to your weight gain:

Emotional Eating ☐	Portion Sizes ☐	Stress Eating ☐
Compulsive Eating ☐	Late Night Eating ☐	Lack of Exercise ☐
Injury Prevents Exercise ☐	Trouble knowing what foods to eat ☐	Unmotivated ☐

Social and Personal History

Do you live alone? Yes☐ No☐ Do you have children? Yes☐ No☐

If yes, what are the children's age(s)? _____

Do you currently exercise? Yes☐ No☐ If yes, frequency? _____

Any injuries preventing you from exercising? Yes☐ No☐

Does your weight affect your ability to work? Yes☐ No☐

Does your weight affect your home life? Yes☐ No ☐

What activities do you enjoy? _____

Do you smoke cigarettes? Yes☐ No☐ # Per day_____ # of Years_____

Do you Vape? Yes☐ No☐

Do you drink alcohol? Yes ☐ No☐ Type_____ # Per week_____

Do you use illegal drugs? Yes☐ No☐ Type _____ # Per week_____

Do you use medical marijuana? Yes☐ No☐ How often? _____

Are you currently receiving psychiatric/psychological service at this time? ☐ Yes or ☐ No

If yes, by whom_____

Are you currently being treated for depression? Yes☐ No☐

List other reasons for weight gain: _____

_____

_____