Love to Live Well Intake Form for Families

Health Assessment Patient Questionnaire

Name (parent): ____ Date: _______________

How you heard about us: ____

Primary reason for your visit: ____

Top 2 goals you would like to achieve for you and your family by working with *Love to Live Well*:

1 ____

2 ____

Top 2 reasons you want to achieve them (what motivates you to make these goals happen?):

1 ____

2 ____

Background Information (completed by parent only)

Age: ____________ Birth date: ____________ Preferred phone number: __________________

E-mail: _______________________________ Occupation: ____________________________

Work hours: _________________________ Marital status: _____________________________

Highest level of education: ____

Please list the people in your household and their relationships to you:

____

General Health Information (complete with primary client info)

Physician's name: _________________________ Physician's phone: ____________________

Physician's address: ____

Date of most recent physical exam: ____________ Date of most recent blood tests: __________

How do you rate your health? ______ Poor ______ Fair ______ Good ______ Excellent

Name of each Family Member	Height (in)	Weight (in)	Age (yrs)	Birth Date	Ideal Body Weight (what you would like to weigh)	Year you last weighed this
				/ /		
				/ /		
				/ /		
				/ /		
				/ /		

Review of Systems ***(circle all that you currently have or are concerned about and write name of family member to whom this applies beside the condition)***

Respiratory	**Cardiovascular**
Shortness of breath	High blood pressure
Coughing	Heart disease/heart attack
Asthma or wheezing	Congestive heart failure
Emphysema	Heart murmur
Snoring	Irregular heartbeat or palpitations
Daytime sleepiness	Chest pain or discomfort
Disturbed sleep	Ankle or feet swelling
Sleep apnea	Varicose veins
History of pneumonia, chronic bronchitis, or COPD	Blood clots or clotting disorders
Genitourinary	**Endocrine**
Difficulty urinating	Diabetes mellitus
Urinary incontinence (leaking urine)	High cholesterol
Inability to empty bladder fully	Thyroid disease
Recurrent urinary tract infections (UTIs)	Gout

Infertility Sexual problems Abnormal menstrual periods Enlarged prostate	High triglycerides **Musculoskeletal** Aching muscles or joints Lower back pain/disc problems Arthritis
Gastrointestinal Nausea/vomiting Abdominal/stomach pain Heartburn/acid reflux Belching/burping Ulcer disease Rectal bleeding or blood in stools	**Gastrointestinal cont'd** Constipation Diarrhea Gallbladder disease/gallstones Celiac disease Hernia Hemorrhoids
Skin and Hair Skin sores or infections (boils, ulcers, skin fold irritations) Bruises easily Chronic rashes or dermatitis or eczema Excessive facial/ body hair (women only) **Cancer** (list type): ____________________ ____________________ **Other Serious Medical Conditions** (list types): ______________________________	**Other** Low energy level Depression Bipolar disorder Attention deficit disorder (ADD) or attention deficit and hyperactivity disorder (ADHD) Anxiety disorder or panic attacks Obsessive-compulsive disorder (OCD) Psychological or psychiatric care History of child abuse, rape, or molestation History of being subjected to any physical or verbal abuse Binge eating

______________________________ ______________________________	Bulimia Anorexia Anemia Headaches or migraines Peri/post menopausal

Do you have a family history of any of the following? (Circle all that apply)

High blood pressure, high blood cholesterol, diabetes, thyroid disease, obesity, heart disease, cancer, other (list):

____

List the types of surgeries you have had:

____

List all prescription and over-the-counter medications that you currently take (include the dosages): **(or bring a list of these with you for my records for each member of your family)**

____

____

____

List all vitamins, minerals, supplements, and herbs that you take: **(or bring a list of these with you for my records for each member of your family)**

____

____

Stress/Coping Information (completed by parents only, include initials by answers)

How often do you use tobacco? _______/week How often do you drink alcohol? _______/week

If so, how much? __________cigarettes or packs/day or week _________drinks/day or week

What type of alcohol? ________________

How often do you use energy drinks (like Red Bull or 5 Hr Energy)? ___________ /day or week

If so, what type? ______________________

How many hours of sleep do you average per night? _______ Is your sleep restful? Yes or No

On a scale from 1 (low stress) to 5 (high stress), how would you rate your daily stress level?

1 2 3 4 5

How do you cope with stress in your daily life?

____

What are your top stressors (things that make you stressed)?

____

Who are the top 3 people in your social support structure (relationships: e.g. daughter, spouse):

____

On a scale from 1 (weak) to 5 (strong), how would you rate your social support network?

1 2 3 4 5

Is your work/home environment supportive of making changes in eating better, moving more, and stressing less? If not, please explain:

____

____

On a scale of 1 (not ready) to 5 (very ready), how ready are you to make lifestyle changes?

1 2 3 4 5

On a scale of 1 (not at all confident) to 5 (very confident), how confident are you to make lifestyle changes?

1 2 3 4 5

What makes it hard for you to lose weight and keep it off?

____

____

Nutrition Information

What one or two things would you like to change about your family's diet?

____

What dietary limitations (dislikes, intolerances, avoidance of textures/tastes) do your family members have? **Please list these by family member.**

____

____

Please list any food allergies/sensitivities or religious/cultural beliefs that affect your heath care or diet: **Please list these by family member.**

____

In the following chart, describe when and what you usually eat in a typical day. (Write "None" if you do not eat that meal or snack.)

Meal	Time	Foods Eaten	Amounts
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			

Do you have difficulty getting meals prepared? Y or N If so why?

- ☐ Time/prep issues
- ☐ Don't like to cook
- ☐ Don't know how to cook

Other (please specify)________________________

Please describe how any of your family member's daily meals differ from what you put in the table above:

____

____

Physical Activity Snapshot

Name of each Family Member	What is the most physically active thing you do in an average day?	What, if any, regular exercises do you do?	How often and for how long do you participate? (e.g. ? minutes for ?x per week)	Do you know of any reason(s) why you should not do physical activity? If yes, please explain the reasons.

Food/Activity Snapshot (completed by parents only)

For this next section, please think of the your typical food intake/activity and please list the:

____ ____ **Initials for parents, then put your answers below your initials**

____ ____Servings of **Veggies**/day you ate (1 serving = ½ cooked or 1 c raw veggies)

____ ____Servings of **Fruits**/day you eats (1 serving = ½ c canned, fresh, or frozen fruit)

____ ____Servings of **Fruit Juice**/day you drank (1 serving = ½ c)

____ ____Servings of **Soda**/day you drank (1 serving = 12 oz can)

____ ____Servings of **Milk or Yogurt**/day you drank/ate (1 serving = 8 oz)

Type of milk you drink/yogurt you eat **(circle one):** skim 1% 2% whole

____ ____Number of **Sweets** (candy, candy bars, chocolates, cookies, ice cream) you eat/day or week (if less than once per day) **(please circle day or week, whichever fits best)**

____ ____Number of **Snacks** you eat/ Day or Week (if less than once per day) **(please circle day or week, whichever fits best)**

____ ____Number of times you **skip a meal**/day or week (if less than once per day) **(please circle day or week, whichever fits best)**

____ ____Times you eat out at a **casual dining restaurant (sit-down restaurant**)/day or week (if less than once per day) **(please circle day or week, whichever fits best)**

____ ____Times you eat out at a **fast food** restaurant/day or week (if less than once per day) **(please circle day or week, whichever fits best)**

____ ____Times you eat **fried foods** (French fries, fried chicken, breaded meats, potato/tortilla chips) /day or week (if less than once per day) **(please circle day or week, whichever fits best)**

____Hours/day you watch **TV or play video games**.

____Hours/day you **sit at a computer**.

Please describe how any of your family member's responses differ from what you put in the section above:

____

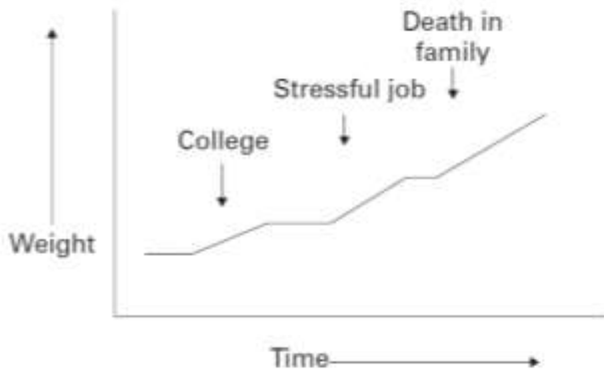
____

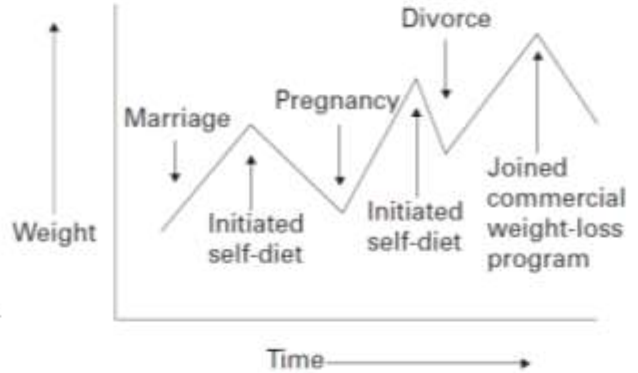
For this next section, please think of the <u>a typical week</u> and list:

What are the **3 most common beverages** you/your family drink?	What are the **3 most common foods** you/your family eat?	What are the **3 most common snacks** you/your family eat?	What are the **top 3 ways you/your family like to be active**?
1	1	1	1
2	2	2	2
3	3	3	3

Weight History Graph (completed by parents only)

Most people can relate changes in their weight to different life events. The following graphs illustrate two examples of how people have gained weight.





Please draw a graph of your weight gain. Mark *life events* and *diet attempts* that have contributed to your current weight. Please include ages at points where your weight changed.