Love to Live Well Intake Form

Health Assessment Patient Questionnaire

Name: _____ Date: _____

How you heard about us: _____

Primary reason for your visit: _____

Top 2 goals you would like to achieve 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

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

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

Height: _____ Weight: _____

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)

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

Gastrointestinal	**Gastrointestinal cont'd**
Nausea/vomiting	Constipation
Abdominal/stomach pain	Diarrhea
Heartburn/acid reflux	Gallbladder disease/gallstones
Belching/burping	Celiac disease
Ulcer disease	Hernia
Rectal bleeding or blood in stools	Hemorrhoids
Skin and Hair	**Other**
Skin sores or infections (boils, ulcers, skin fold irritations)	Low energy level
Bruises easily	Depression
Chronic rashes or dermatitis or eczema	Bipolar disorder
Excessive facial/ body hair (women only)	Attention deficit disorder (ADD) or attention deficit and hyperactivity disorder (ADHD)
Cancer (list type): _____	Anxiety disorder or panic attacks
_____	Obsessive-compulsive disorder (OCD)
Other Serious Medical Conditions (list types):	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)

_____

_____

_____

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

_____

_____

Stress/Coping Information

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 diet?

_____

_____

What dietary limitations (dislikes, intolerances, avoidance of textures/tastes) do you have?

_____

Please list any food allergies/sensitivities or religious/cultural beliefs that affect your heath care or diet:

_____

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)_____

Physical Activity Information

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?

_____

Do you know of any reason(s) why you should not do physical activity? If yes, please explain the reasons.

_____

Food/Activity Snapshot

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

____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**.

Was this a typical week for you? Y N

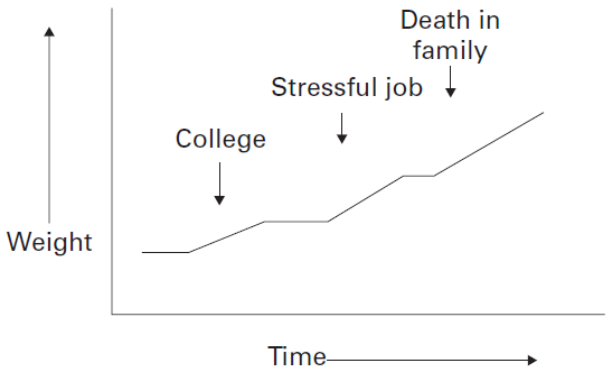
For this next section, please think of the <u>a typical week</u> and list:

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

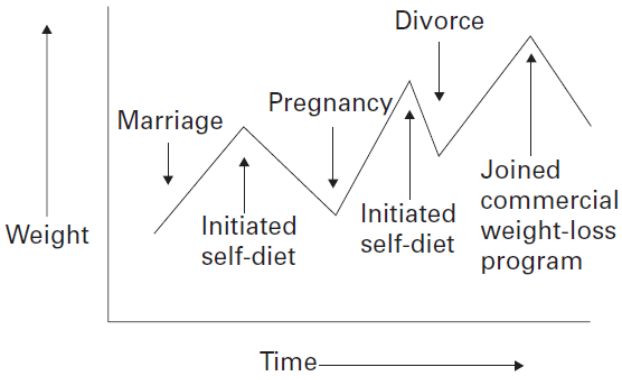
Weight History Graph

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

Progressive (or Ratcheting) Weight Gain



Weight Cycling or "Yo-Yo" Weight Gain



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.