New Client Questionnaire: Nutrition & Weight Loss

This questionnaire is designed to help your providers understand more about you. The primary purpose of asking these questions is to develop a treatment plan that will best suit your weight loss goals. By completing these questions as completely and honestly as you can, we will be able to offer you care in alignment with your needs. We are education-focus based on the latest research in weight loss. Our goal is to assist you in developing healthy lifestyle habits to assure safe weight loss/improved health status. We work collaboratively with your medical team as part of a comprehensive multi-disciplinary team.

Who referred you to us:

Date

First Name:		**MI:**	**Last Name:**
Birthdate:	**Age:**	**Gender:**	**Email:**
Local Mailing Address:	**Home Phone:** **Work Phone:** **Pager or Cell phone:**		**Ethnic Group** *(please circle one)*: American Indian or Alaskan — White, Not of Hispanic Origin Latino or Hispanic — Black, Not of Hispanic Origin Asian or Pacific Islander — Other:_____
Occupation:			**Education (School, Degree, GPA -if in HS)**
Rate your level of occupational stress: (0-10) with "0" no stress/"10" most stress 0 1 2 3 4 5 6 7 8 9 10			Are you currently pursuing education/certification? **No Yes:**
Marital Status *(please circle one)* Single Engaged Married Separated Divorced Widowed Living with a partner			**Length of time in current relationship:**
Spouse/Significant other's first name:			**Is your spouse over weight? Yes No**
Please list your children's names, ages and genders			
Military Status *(circle one)*: Active Duty Retired Reserves	Rank:	**Branch of Service** *(circle one)*: Air Force Army Navy Marines Coast Guard National Guard Other:	
Last known weight/date:	Highest weight: (and when):	How often do you weigh yourself?	

When did weight become a problem?

Briefly describe your reason for wanting to lose weight at this time?

How many meals per day to you typically eat on a consistent basis? Breakfast Lunch Dinner
Do you snack? If so, please describe:

Weight Loss History

Please check all that apply.

Have you experienced:	**Currently** (in the last week)	**Recently** (in the last 6 months)	**Previously** (over 6 months ago)	**Never**
Taken prescription medication for weight loss (i.e. Orlistat)				
Taken over the counter weight loss products				
Participated in formal weight loss program (i.e. Weight Watchers, Jenny Craig, Nutrisystem)				
Independently followed a weight loss program (i.e. Atkins, South Beach Diet, etc.)				
Received group counseling for weight loss				
Received individual counseling for weight loss				
Attended low impact exercise classes (i.e. yoga, tai chi, pilates)				
Attended high intensity exercise classes (i.e. kick boxing, martial arts, step classes, spinning)				
Exercise (cardio for a min. 20 min) regularly (at least 3 days per week)				
Exercise (cardio for a min 20 min) regularly 1-2 days per week.				
Received or self-taught lesson on how to count calories				
Received of self-taught lesson on how to do food exchanges				
Used a journal/nutrition log to track progress				
Been diagnosed with an eating disorder by a medical professional				
Restricted caloric intake to below 1000 calories per day				
Used diuretics (water loss pills) or laxatives (pills, tea)				
Binged on food (consumed over 800 calories in a sitting)				
Purposefully made yourself vomit (purged)				

Physical Symptoms

Please check the physical symptoms that have been a problem for you over the past month.

	Dry mouth		Tics/Twitches		Fainting or dizzy spells
	Constipation		Chest pain		Swollen ankles
	Fatigue		Chills/Hot flashes		Trembling/Shaking
	Choking sensation		Urinary problems		Changes in hearing or vision
	Stomach problems		Constant pain		Fainting or dizzy spells
	Nausea		Muscle tension		Blackouts
	Diarrhea		Difficulty urinating		Unexplained weight loss
	Headaches		Shortness of breath		Unexplained weight gain
	Sweating		Exercise		Other:

MENTAL HEALTH HISTORY

Please check any of the following that apply regarding present or past treatment

	Currently seeing a psychiatrist? Prescribing MD		Previously seeing a psychiatrist but not now
	Currently seeing a therapist for individual counseling		Previously seeing a therapist
	Currently seeing a therapist for couples or family counseling		Previously seeing a couples or family therapist
	Currently seeing a pain management physician		Previous pain management treatment
	Currently seeing a physician for addiction treatment		Previous addiction treatment

If you are currently under the care of a counseling professional, would you like them to be a part of your weight loss treatment team?
Yes or No Comments: _____

FAMILY MENTAL HEALTH HISTORY

Please check the mental health conditions or treatments that apply to any members of your family. Please enter the appropriate letter(s) to indicate which family member after the condition (M=Mother, F=Father, S=Sister, B=Brother, A=Aunt, U=Uncle, GP=Grandparents.

	Attention Deficit Hyperactivity Disorder or Attention Deficit Disorder		Learning Disability		Mental Retardation
	Psychosis (such as schizophrenia)		Bipolar Disorder or Manic Depressive Illness		Depression
	Anxiety Disorder (such as panic disorder, phobia, or very excessive worry)		Alcohol or Drug Abuse		Hospitalized for Mental Health Problem

MEDICAL HISTORY

Please check the medical problems/conditions or treatments that **apply to you now or in the past.**

	Diabetes		Ulcers		Tuberculosis (TB**)**
	High Blood Pressure		Celiac Sprue/gluten enteropathy		Genital problems
	Irregular heart beat		Pancreatitis		Urinary problems
	Elevated cholesterol		Fibromyalgia		AIDS or HIV positive
	Elevated triglycerides		Arthritis		Cystic Fibrosis
	Dyslipidemia		Headaches		Liver Disease
	Thyroid Disease		Back/neck pain		Hepatitis or Cirrhosis
	Kidney Problems		Breathing problems		Stroke
	Anemia		COPD		Seizures
	Problems digesting food		Cancer		Sickle cell disease
	Irritable bowel syndrome		Radiation therapy/Chemotherapy		Other:
					Other:

Are you seeing a physician on a regular basis to deal with a medical problem? YES NO If yes what condition?
Are you experiencing physical pain? YES NO
If yes, what is usual level of that pain? No pain 0 1 2 3 4 5 6 7 8 9 10 Extreme pain
When was your last physical?
FEMALES ONLY: Currently pregnant? YES NO Possibly pregnant? YES NO
Last Menstrual period:

MEDICATION

Please list any medications you are currently taking or have taken within the last year (include aspirin, laxatives, birth control pills or alternative or herbal medicines)

Medication	Dosage	Date Began	Date Ended (if applicable)	For What

ALLERGIES

Are you allergic to any medications? YES NO Are you allergic to any foods? YES NO

If YES to either of the above, please give details.

Substance:	Response:
Substance:	Response:
Substance:	Response:
Substance:	Response:

FAMILY MEDICAL HISTORY

Please check the medical conditions or treatments that apply to any members of your family. Please enter the appropriate letter(s) to indicate which family member after the condition (M=Mother, F=Father, S=Sister, B=Brother, A=Aunt, U=Uncle, GP=Grandparents.

	Heart disease or condition		Anemia		AIDS or HIV positive
	High blood pressure		Headaches		Huntington's disease
	Stroke		Ulcers		Seizures
	Diabetes		Pancreatitis		Cancer
	Tuberculosis (TB)		Cirrhosis		Arthritis
	Thyroid Disease		Hepatitis		Other:

PSYCHOSOCIAL HISTORY

Family/Life History (there is often a correlation between significant life events and eating patterns)

Please check any of the following events that applied to you as a child, adolescent or adult:

	Happy Childhood		Abusive Relationship
	Unhappy Childhood		Rape
	Death of parent		Miscarriage
	Death of someone close		Abortion
	Filed for bankruptcy		Crime victim
	War/ As a citizen or active duty service member		Natural disaster
	Poverty		Been diagnosed with PTSD

Learning/Education

Is English your primary language? YES NO If no, please explain:					
Do you have any difficulty reading and writing? YES NO If yes, please explain:					
Check any of the following that apply to how you learn best:					
	Listening to others speak		Watching someone else do something		Talking to my peers
	Reading on my own		Watching someone else then doing it myself		

Please check any of the following that applied to you during your education (grade school, high school, and/or college)

	Bullied about weight/appearance		Being involved in my activities		Being suspended or expelled
	Low grades		Being held back a grade		Few friends
	High grades		Skipping ahead a grade		Truancy

Religion/Spirituality (Adapted from Strayhorn's Religiousness Scale, 1990) Please circle the answer that applies

When you make decisions in your everyday life, how often do you ask God for help with the decisions? 1. never 2. seldom 3. sometimes 4. often 5. very often
To what extent is the direction of your life influenced by some religious goal or purpose? 1. not at all 2. to a small extent 3. to a moderate extent 4. to a large extent 5. to a very large extent
What is your Religious Denomination?:

Alcohol Use

Please check any of the following that apply to you:	YES	NO
Do you drink alcohol now or have you in the past (including beer and wine)? If yes, please answer the following:		
• Has your alcohol use increased in the past month?		
• Have you had problems in your relationships with friends or family due to alcohol use?		
• Have you had problems at work or at home due to alcohol use?		
• Have you blacked out in the past from drinking alcohol?		
• Have you ever been in treatment for over use of alcohol (including AA, Rational Recovery, etc.)?		
• Have you had trouble with the law due to alcohol use (i.e. DUI, drinking underage, public intoxication, alcohol-related violence)?		
• Do you drive after drinking alcohol?		
• How many drinks to get a "buzz"?		
• How many drinks to feel drunk?		

Other Substances

Please check any of the following that apply to you:	YES	NO
Do you use tobacco products? If yes, please answer the following		
• Kind: Amount per day?		
• Began use at what age?		
Do you drink caffeinated beverages? If yes, please answer the following		
• Kind: Amount per day?		
• Kind: Amount per day?		

GOALS FOR TREATMENT

1. _____

2. _____

3. _____

What percentage of confidence (0 – 100%) do you have that you can help yourself reach these goals *without* any assistance from this weight loss program?

0% 10 20 30 40 50 60 70 80 90……100%
Not at all Confident — Totally Confident

What percentage of confidence (0 – 100%) do you have that you can help yourself reach these goals *with* assistance from this weight loss program?

0% 10 20 30 40 50 60 70 80 90……100%
Not at all Confident — Totally Confident

Thank you for completing this portion of the assessment.

Signature: _____ **Date** _____

Thank you, Your Allied Health Group: 10560 Main Street, LL 15, Fairfax, VA 22030

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