SIMPLY HEALTH
Wellness and Weight Loss

Personal Information ***Date***

Name_____

Address City, State, Zip_____

Telephone (Mobile)_____

Date of Birth_____Age_____Height_____Email_____

Occupation_____

Employed By_____

How were you referred to our office?_____

Medical History

Do you have any of the following?

____Depression	____Epilepsy	____Headache	____Heart Attack
____Hypoglycemia	____Neck Pain	____Diabetes	____Anemia
____Poor Sleep	____Thyroid	____Cancer	____Dizziness
____Gallbladder	____Gall Bladder Disease		____Intestine Problems
____Arthritis	____Shortness of breath		____High Cholesterol
____Gout	____Stroke	____Kidney Disease	____Carpal Tunnel
____Mid back pain	____Low back pain	____Hypertension/High Blood Pressure	
____Asthma	____Allergies	____AutoImmune Disease	

History

Are you pregnant?_____ Are you breast feeding?_____

Do you smoke?_____ How many packs per day?_____

Do you drink alcohol?_____ How much per day?_____

Any know allergies?_____ If so to what?_____

How much water do you drink daily?_____

List all sugeries and dates_____

_____

Has your primary care physician recommended you lose weight?_____

Who is your primary care physician?_____

What prescription medications do you currently take?_____

_____

Are you short of breath because of your weight?_____

How long have you been overweight?_____

Can you attribute anything specific to your weight gain?_____
What have you tried in the past to lose the weight?_____

_____

What are your top 2 reasons for wanting to lose weight?_____

_____

What is your energy level on a scale of 1-10, (1= lowest 10=highest)?_____
How many hours of sleep do you get at night?_____Good quality sleep?_____
If you suffer from a lack of energy, does it prevent you from doing things with your family?_____

How much did you weigh when you were the most comfortable with yourself?_____

Describe in detail, exactly how you felt?_____

_____

Describe, IN DETAIL, how you feel NOW verses when you were comfortable with yourself?_____

_____

_____

Because of your current weight, what can you no longer do that you used to be able to?_____

_____

_____

Why do you feel other diets/things you have tried did NOT work for you?_____

_____

How long have you been overweight?_____
How long have you been thinking about losing weight?_____
On a typical/average weekday, how much do you spend on foods that have contributed to your being overweight?_____
Do you TRULY believe that you can do this (lose weight and get healthier), provided you were given a "system" that truly worked and were supported fully through your journey/transformation, why or why not?_____

_____

_____

Please list any potential obstacles (time constraints, budget, commitment, spouse, etc) _____

_____

_____

On a scale of 1-10, (1=not interested, 10=I am fully committed to start NOW) What is your commitment level and why?_____

_____