

FOR OFFICE USE ONLY

Initial Weight _____ Age _____ Height _____ Ideal Weight _____ Must Lose _____

Treatment Weeks _____ 1/2 Way Point _____ Goal Date _____

Initial Body Fat % _____ BMI _____ Waist _____

Program Director _____

Notes:

Healthy Habits Wellness Clinic

LIFESTYLE QUESTIONNAIRE
Health Risk Analysis

Today's Date: ____/____/____ DOB: ____/____/____ Age: ____ Height: _____ Gender: **F M**

Last Name _____ **First Name** _____

Address _____ City _____ State _____ Zip _____

Email: _____ Cell: (____) _____ - _____

How did you hear about us? _____ If referred by someone, who? _____

Please answer the following questions honestly so we can do our best to help you reach your goals.

What made you decide to do something about your weight today? _____

Who encouraged you to lose weight? _____ Can you commit to one visit a week? **Y N**

What important reason, special occasion, or goal date do you have for wanting to lose weight? _____

How important to you is it that you lose weight? _____ What is your current weight? _____

How many pounds would you like to lose? _____ How fast do you want to be slim, trim & fit? _____

Have you ever attended any other weight reduction centers, if so, which ones? _____

What kinds of diets have you tried on your own? _____

What is the longest you have been able to stick with a diet? _____

Does your family support your weight loss efforts? **Y N**

Have you been advised by your family physician to lose weight? **Y N**

If yes, what is your doctor's name? : _____

Do you eat because of emotions? **Y N**

If yes, please explain: _____

On average, which of the following reflects your daily eating habits? (Please check all that apply.)

- | | |
|---|--|
| <input type="checkbox"/> 3 meals with healthy snacks | <input type="checkbox"/> Skip breakfast or other meals |
| <input type="checkbox"/> 3 meals | <input type="checkbox"/> Generally eat on the run |
| <input type="checkbox"/> 2 meals or less | <input type="checkbox"/> No regular eating pattern |
| <input type="checkbox"/> Graze; small, frequent meals (How many per day? _____) | <input type="checkbox"/> Often crave sweets/carbs |

Please check your current level of exercise:

- None**
- Light exercise:** 1-3 times per week, easy pace, stretching, walking, etc.
- Moderate exercise:** 2-3 times per week, moderate pace, some weights, etc.
- Heavy exercise:** 3-4 times per week, vigorous pace, weights, fast running, etc.

HEALTH INFORMATION
Past or Present Health Conditions:

- | | | | |
|----------------------|------------|--------------------|------------|
| DIABETES: | Y N | HORMONE IMBALANCE: | Y N |
| HYPOGLYCEMIA: | Y N | THYROID IMBALANCE: | Y N |
| STROKES: | Y N | ANOREXIA: | Y N |
| HEART DISEASE: | Y N | BULIMIA: | Y N |
| HIGH BLOOD PRESSURE: | Y N | DRUG ADDICTION: | Y N |

- ARE YOU CURRENTLY PREGNANT OR NURSING? **Y N**
- ARE YOU ALLERGIC TO SULFUR, FOOD OR MEDICATION? **Y N**

If you answered YES to any of the above, please explain: _____

Have you ever been hospitalized, under medical care, or checked into rehab for alcohol or drug treatment? **Y N**

If YES, please explain: _____

Please list any and all medications you are currently taking, including doses and reasons for taking:

Food and Chemical Sensitivity Survey

Please complete the following survey using the key below:

- = no symptoms (zero points)
- = mild symptoms (one point)
- = moderate symptoms (two points)
- = severe symptoms (three points)

Digestive Symptoms

- Stomach pains or cramping
- Constipation
- Diarrhea
- Reflux or heartburn
- Bloating
- Gas

Weight

- Inability to lose weight
- Food cravings
- Binge eating
- Nausea or vomiting
- Water retention

Sinus/Respiratory

- Stuffy or runny nose
- Asthma
- Chest congestion
- Chronic cough
- Frequent sneezing

Head/Ears

- Migraines
- Headaches
- Earaches
- Wheezing
- Ear infection
- Ringing in ears

Eyes/Throat

- Itchy eyes
- Watery eyes
- Sore throat
- Persistent canker sores

Emotional/Mental

- Depression
- Anxiety
- Mood swings
- Irritability
- Poor concentration

Energy

- Fatigue
- Lethargy
- Restlessness
- Insomnia
- Hyperactivity

Skin Disorders

- Dermatitis
- Excessive sweating
- Rashes
- Hives
- Eczema

Other symptoms

- Joint pain
- Arthritis
- Irregular heartbeat
- Chest pains
- Muscle aches

(office use only)

TOTAL SCORE: _____

Please list any symptoms you experience that were not previously mentioned: _____

What is the most important element in deciding to use our services? (Circle only one)

- EFFECTIVENESS:** "My results are my top priority."
- TIME:** "I want results quickly."
- SERVICE:** "I need extra support along the way."
- EASE:** "I have a difficult time losing weight."

I understand that my patient file will be kept completely confidential unless I give written permission for my information to be released.

Signature: _____ Date: _____