Weight Loss Questionnaire

Name: _____ Date of Birth: _____ /_____ /_____

Home Phone Number: _____-_____-_____ Cell Phone Number: _____-_____-_____

Do you have a smartphone? Yes No Email Address: _____

How often can you visit us for weight checks: Weekly Biweekly Monthly Other_____

Describing My Current Climate

Current stress level	None	Low	Medium	High
The biggest stressor	Job	Relationship	Other:	
Tobacco use	Current	Former	Never	Quitting
Alcohol use	None	Occasional	Weekly	Daily
Recreational substance use	None		Type/Frequency:	
I have had a problem with drug or alcohol addiction in the past		Yes	No	Which?

Weight: _____ lb Height: _____ in BMI: _____

$(weight/height^2 * 703)$

My weight **1** year ago was: _____ lb My weight **5** years ago was: _____ lb

Lowest weight since adulthood was: _____ lb Highest weight since adulthood was: _____ lb

The **MOST** I ever weighed (non-pregnant) was: _____ lb

My **worst** food habit is: _____

I am a **stress** eater: ☐ Yes ☐ No

I eat in the middle of the night: ☐ Yes ☐ No

My significant other has a weight issue: ☐ Yes ☐ No ☐ N/A

During the last 3 months, I have had episodes of excessive overeating where I ate more than what most people would eat in a similar period of time: ☐ Yes ☐ No

- *If "No" go to Beverage box below*
- *If " Yes" complete the following:*

During these episodes I feel I have NO CONTROL over my eating ☐ Yes ☐ No

I eat during these episodes even when I am not hungry ☐ Yes ☐ No

During these episodes I feel embarrassed by how much I ate ☐ Yes ☐ No

During these episodes I feel disgusted with myself, or guilty afterward ☐ Yes ☐ No

In the past 3 months, I have sometimes made myself vomit to try to control my weight ☐ Yes ☐ No

Beverage: I drink the following routinely (circle all that apply)

Beverage	Number per week
Fruit Juice	
Sweetened Tea	
Sports Drinks	
Energy Drinks	
Regular Soda	
Diet Soda	

Typical Meals for me include: (if "none", please note that)

Breakfast	Lunch	Supper	Sneaks

I have done the following ***weight loss programs*** before:

Program	Year	Result

I have used weight loss medication before: Yes No If yes, which?_____

I am currently using weight loss products: Yes No If yes, which?_____

Family History (please indicate first degree relatives only)

☐ Heart Attack/Stroke ☐ Diabetes ☐ Obesity

☐ Psychiatric ☐ Cancer ☐ Other:_____

My Past Health History

My regular PCP is: _____ Phone Number: _____

Previous or Current Health Conditions I have had include: (check all that apply to you)

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Chronic Leg Swelling
- ☐ Bleeding Disorder
- ☐ Blood Clot
- ☐ Anemia
- ☐ Cancer
- ☐ Eczema
- ☐ Depression
- ☐ Anxiety
- ☐ PTSD
- ☐ Binge Eating Disorder
- ☐ Anorexia Nervosa
- ☐ Bulimia
- ☐ ADHD/ADD
- ☐ Bipolar Illness
- ☐ Pancreatitis
- ☐ Headache/Migraine
- ☐ Sleep Apnea
- ☐ Asthma
- ☐ COPD
- ☐ Acid Reflux
- ☐ Irritable Bowel/Colitis
- ☐ Fatty Liver
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Liver/Gallbladder Disease
- ☐ Stomach Ulcers
- ☐ Thyroid Cancer
- ☐ Gout
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Urinary Incontinence
- ☐ Polycystic Ovaries
- ☐ Menopause
- ☐ Other:_____ _____

Surgeries I have ever had include:

Type	Date

Prescription Medications I CURRENTLY take are:

Medication Name	Dose and Frequency	Medication Name	Dose and Frequency

Supplements I CURRENTLY take are:

Type	Date

Any medication allergies? _____

Weight Loss Program Policy & Agreement

**Please read the below information and sign prior to first visit*

1. I understand that all weight loss sessions, whether in-person or via phone/tele-visit are considered a scheduled appointment time. I am aware that if I cannot make my scheduled appointment, it is my responsibility to call and cancel or reschedule. Patients should call the clinic if an appointment must be canceled or rescheduled at least 1 full business day prior to scheduled appointment.
2. As a client, I understand and agree that I am fully responsible for my physical, mental and emotional well-being during my calls, including my choices and decisions. I am aware that I can choose to discontinue coaching at any time.
3. I understand that weight loss program is a comprehensive process that may involve all areas of my life. Utilizing a whole person approach may include discussing subjects such as work, finances, health, relationships, education, spiritual and recreation. I acknowledge that deciding how to discuss these issues, incorporate coaching into those areas if needed, and implement my choices is exclusively my choice and personal responsibility.
4. I understand that coaching does not involve the diagnosis or treatment of mental disorders as defined by the American Psychiatric Association. I understand that coaching is NOT a substitute for counseling, psychotherapy, psychoanalysis, mental health care or substance abuse treatment. I further agree that I will not use it in place of any form of diagnosis, treatment or therapy.
5. I promise that if I am currently in therapy or otherwise under the care of a mental health professional, that I have consulted with the mental health care provider regarding the advisability of working with a health coach.
6. I understand that my information will be held as confidential and only shared as needed between health coach and provider for best health outcomes, unless I state otherwise, in writing, except as required by law.
7. I understand that coaching is not to be used as a substitute for professional advice by legal, medical, financial, business, spiritual or other qualified professionals. I will seek independent professional guidance for legal, medical, financial, business, spiritual or other matters. I understand that all decisions in these areas are exclusively mine and I acknowledge that my decisions and my actions regarding them are my sole responsibility.

_____ _____

Signature Date

Weight Loss Program Consent Form

I, _____, authorize my Music City Primary Care physician(s), or advanced practice clinician(s) and/or whomever may be designated as the medical assistant(s), to help me in my weight reduction efforts. I understand that my program will consist of a prescribed diet, a regular exercise program, instruction in behavioral modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low caloric diet, some form of fasting, or a protein supplemented diet. I further understand that if appetite suppressants are prescribed, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me to my complete satisfaction that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the medication product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks associated with remaining overweight are tendencies to have high and increasing higher blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances made to me that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require drastic changes in eating habits and permanent changes in behavior to be treated successfully.

APPOINTMENT CANCELLATIONS AND NO-SHOWS

We understand that situations arise in which you must cancel your appointment. It is required that if you must cancel your appointment, you provide **24 hours notice**. Providing advanced notice is a courtesy to your provider and allows another patient to be seen. Without notification, you are subject to a late cancellation fee or a no-show fee. We understand that special unavoidable circumstances may cause you to cancel within 24 hours prior to your appointment. Fees in this instance may be waived, but only with management approval.

_____ (initial) I understand that office appointments which are canceled with less than 24 hours notice are subject to a **$35.00** cancellation fee.

_____ (initial) I understand that if I no-show an appointment, I will be charged **$35.00** to reschedule an office appointment and to reschedule a procedure appointment.

_____ _____

Signature Date