Name: ________________________________ **Date:** ___________________________

INTAKE FORM

at Oregon Medical Weight Loss & Wellness

Best # to reach you ______________________ May we leave a message here, for you? (Y/N)
Social Security Number __________________
Address:________________________________ Email address _____________________________________
City________________State_____Zip_______ May we send you email information about weight loss? (Y/N)
Age ________________D.O.B._____________ Primary Care Provider________________________________
Occupation_____________________________ What is your preliminary goal weight?_________________
How did you hear about us? □ I'm a current patient □ A friend □ Referred by __________________________
On line via: □ Oregon Medical Weight Loss □ SW Family Physicians □ Other____________________

Current Marital Status (circle one): Single Engaged Married Separated Divorced Widowed Domestic Partner
Are you content with your current status? YES NO If no, please explain: __________________________________
____
What is your main reason for deciding to lose weight now? ____
List activities you are **not** doing now, but would **like** to do in the future: _______________________________________
When did you begin gaining excess weight? (Give reasons if known): ____
____
What has been your maximum lifetime weight (non-pregnant) and when? ___________________________________
Has your weight changed in the last 2-3 months? ____
Any history of eating disorders, now or in the past? Please explain ____________________________________
____
What are your expectations of us (your medical team)? Be specific: ____
____

Previous diets you have followed	Dates	Results of your weight loss	Any weight regained?

Which was you best "diet success" and why did it work well for you. ____
____

How often do you eat out? _____________________ How often do you eat "fast foods"? _________________________
In your household, who plans meals? ________________ Cooks? ________________ Shops? ______________________
Is your spouse or partner overweight? YES NO If so, approximately how much?_______________________________
Foods you crave? ____
What are your worst food habits? ____
Please describe your snack habits: ____
Do you think alcohol plays a part in your weight gain or makes it harder for you to lose weight? YES NO
Do you awaken hungry or eat during the night? YES NO
Do you feel you are an emotional eater? YES NO Please list circumstances that trigger this emotional eating behavior.____
Have you used appetite suppressants in the past? YES NO If so, which ones? __________________________
What were the results? ____
If your favorite food is in the refrigerator, do you find it hard to sleep well? YES NO

Do you have any interest in getting more information about how the other specialties in our clinic may enhance or assist you in your weight loss? If so, please ask our staff to connect you.

☐ Mental Health/Counseling ☐ Physical Therapy ☐ Hypnotherapy & Guided Meditation
☐ Massage Therapy ☐ Acupuncture

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In the past 24 hours, what did you eat for:

Breakfast	Lunch	Dinner	Snacks

Please list any conditions, illnesses, or treatments that might be relevant to your visit today: ______________________
____

Do you feel you are in good health at the present time? YES NO If not, why? ______________________________

Are you under any other doctor's care at the present time? If yes, who? (and for what)___________________________
____

Do you drink sodas? YES NO How much daily? ______________________ Do you use a sugar substitute? YES NO

Do you drink alcohol? YES NO How much daily/weekly? ____

Do you drink coffee or tea? YES NO How much daily? ____

Smoking Habits:

___ I have never smoked cigarettes, cigars, or a pipe.

___ I quit smoking _____ years ago and have not smoked since.

___ I quit smoking at least one year ago and now smoke cigars or a pipe w/out inhaling smoke.

___ I smoke approx _____cigarettes per day (_____ pack/s)

Medication Allergies?_________________________________ Food Allergies?____________________________________

If so, what is your reaction? ______________________________

Please list all prescription medications you are taking at the present time:

Drug	Dosage	Taken for what reason?

Any over-the-counter medications, vitamins, herbs, supplements or natural remedies? ___________________________

Please list all serious injuries and surgeries you have experienced:

Serious injury/surgery	Date

Please indicate your level of **motivation to lose weight** on the scale below:

____

0 **Unmotivated**	**5** **Neutral/Unsure**	**10** **Very Motivated**

Name: ______________________________ Date: ___________________________

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Check ALL the weight related Risks or Diagnoses that you may have:

- ☐ Abdominal Pains
- ☐ Abnormal EKG
- ☐ Abnormal Weight Gain
- ☐ Anemia
- ☐ Anorexia Nervosa (now or in the past)
- ☐ Anxiety
- ☐ Arthritis (specify: _____________)
- ☐ Asthma
- ☐ Breast Cancer
- ☐ Binge Eating patterns/disorder
- ☐ Bulimia/Purging (exercise, laxatives, vomiting, diuretics)
- ☐ Constipation
- ☐ Cushing's Syndrome
- ☐ Decreased Libido
- ☐ Depression/dysthymia
- ☐ Diarrhea
- ☐ Diabetes or
  - ☐ Pre-diabetes
- ☐ Dizziness
- ☐ Eating in the middle of the night
- ☐ Edema
- ☐ Elevated Liver Enzymes
- ☐ Fatigue
  - ☐ Excessive Daytime Fatigue
- ☐ Fibromyalgia
- ☐ Frequent Headaches
- ☐ GERD/Heartburn
- ☐ Gestational Diabetes
- ☐ Glaucoma
- ☐ Gout
- ☐ Hip Pain
- ☐ High Blood Pressure
- ☐ "Pre-Hypertension"
- ☐ High Cholesterol
- ☐ Triglycerides
- ☐ Insomnia
- ☐ Irritable Bowel
- ☐ Knee Pain
- ☐ Low Back Pain
- ☐ Low Blood Sugars
- ☐ Low Testosterone
- ☐ Menopause
- ☐ Migraines
- ☐ Muscle Spasm
- ☐ Nausea
- ☐ Vomiting
- ☐ Osteoporosis
- ☐ Panic Attacks
- ☐ Painful, heavy, or irregular menses
- ☐ Plantar Fasciitis
- ☐ Polycystic Ovarian Syndrome
- ☐ Psoriasis
- ☐ Seizures/Traumatic Brain Injury
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Swelling feet or ankles
- ☐ Thyroid Disorder:
  - ☐ High ☐ Low
- ☐ Ulcer
- ☐ Urinary Stress Incontinence
- ☐ Vitamin D Deficiency

Have any of your **family members** ever had any of the following health problems? *Check all that apply.*

	Name	Alive?	No know history	Cancer	Diabetes	Heart Problems	High Blood Pressure	High Cholesterol	Mental Illness	Stroke	Thyroid Disease	Other
Mother												
Father												
Sister												
Brother												

OB/Gynecologic History: (Women only)

Number of Pregnancies: ____________ Vaginal Delivery or C-Section: ______________________________________

Babies over 9 lbs? YES NO If yes what were their weights? ______________________________________

Menstrual Onset: _______ yrs old Duration: _______ days Last menstrual period: __________

Do you have pain associated with menstrual cycle? YES NO Are menses heavy? ____________

Are you on Birth Control? YES NO If yes, please list: ____

On Hormone Replacement Therapy? YES NO If yes, please list: ____

When was your last Physical/ PAP? ____

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Sleep Questionnaire

Please check any of the following symptoms you are experiencing:

- ☐ Difficulty falling asleep and/or insomnia
- ☐ Excessive daytime sleepiness and/or fatigue
- ☐ Snoring
- ☐ Has any bed partner noticed you not breathing while asleep, waking up gasping or choking?
- ☐ Interrupted sleep patterns
- ☐ Sleepiness while driving
- ☐ Frequent morning headaches
- ☐ Migraines
- ☐ Hypertension
- ☐ Diabetes
- ☐ High cholesterol
- ☐ Obesity
- ☐ Ear pain
- ☐ Neck pain
- ☐ Depression and/or anxiety
- ☐ Teeth grinding and/or clenching
- ☐ Leg movements/restless legs

BMI: _______ (Risk if >30)

Neck circumference: _______ (Risk if: Male > 16.5 in., Women > 15 in.)

Have you already been previously diagnosed with sleep apnea or another sleep related disorder? YES NO

If so, how was your condition diagnosed and what treatment did you receive? ___________________________

If you are using a CPAP device, how often do you use it?

Circle one: every night / almost every night / sometimes / infrequently / never

EPWORTH SLEEP QUESTIONNAIRE

How likely are you to doze off or fall asleep in the following situations?

Never = 0 Slight = 1 Moderate = 2 High = 3

	NEVER chance of dozing	SLIGHT chance of dozing	MODERATE chance of dozing	HIGH chance of dozing
Sitting and reading				
Watching TV				
Sitting inactive in a public place (e.g. a theater or a meeting)				
As a passenger in a car for an hour without a break				
Lying down to rest in the after-noon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a lunch with-out alcohol				
In a car, while stopped for a few minutes in traffic				

Total Score: _________