

Name: _____ Date: _____

BACKGROUND QUESTIONS

Preferred phone: _____ E-mail: _____

Occupation: _____ Work hours: _____

Marital Status (please check): Single Married Divorced Widow Partnered

Please list names of the people in your household and their relationship to you:

Do you own a family dog? Yes No

What is the highest level of education completed? _____

What prompted you to seek services at this time? _____

What are your personal goals we can help you achieve? _____

OVERALL HEALTH QUESTIONS

Primary care provider: _____ Phone: _____

Address: _____

When was your last physical exam? _____ When did you last have blood tests? _____

How would you rate your health? (please check): Excellent Good Fair Poor

Height: _____ Weight: _____

Continued >

Center for Lifestyle Medicine Initial Assessment (continued)

PAST MEDICAL HISTORY Mark (x) all that apply:

Acid Reflux (GERD)	Diabetes (Type 2)	Kidney Disease
Anemia	Emphysema/Chronic Bronchitis	Liver Disease
Anorexia	Epilepsy/Seizure Disorder	Migraines
Anxiety	Fatty Liver Disease	Multiple Sclerosis
Arthritis	Gallbladder Disease/Stones	Obsessive Compulsive Disorder
Asthma/Lung Problem	Glaucoma	Osteoporosis/penia
Attention Deficit Disorder	Gout	Polycystic Ovarian Syndrome (PCOS)
Bipolar Disorder	Heart Disease/Heart Attack	Pacemaker
Bleeding Disorders	Heart Murmur	Prostate Problem
Blood clot/DVT	Hepatitis	Sickle Cell Disease
Bulimia	High Blood Pressure/	Sleep Apnea
Cancer	Hypertension	Stroke
Celiac Disease	High Cholesterol	Thyroid Disease
Congestive Heart Failure	HIV Disease	Tuberculosis
Drug/Alcohol Dependency	Irregular Menstrual Periods	Ulcer Disease
Depression	Impaired Fasting Glucose/	Other
Diabetes (Type 1)	Pre-Diabetes	

REVIEW OF SYSTEMS Mark (x) all that apply:

GENERAL	Fever/chills Fatigue	Weakness Low energy level
RESPIRATORY	Excessive shortness of breath Coughing Wheezing	Snoring Daytime sleepiness Disturbed sleep
CARDIAC	Chest pain Irregular heart beat Palpitations	Ankle or feet swelling Varicose veins
GASTROINTESTINAL	Indigestion/heartburn Nausea/vomiting Abdominal pain Hemorrhoids	Diarrhea Constipation Change in bowel habits Rectal bleeding
GENITOURINARY	Difficulty urinating Urinary incontinence Inability to empty bladder fully Abnormal menstrual period	Recurrent urinary infections Infertility Sexual problems Frequent urination

Continued >

Center for Lifestyle Medicine Initial Assessment (continued)

REVIEW OF SYSTEMS (continued) Mark (x) all that apply:

MUSCULOSKELETAL	Back pain Joint pain Difficulty walking	Muscle cramps Muscle weakness
ENDOCRINE	Excessive thirst Excessive/increased urination	Cold/heat intolerance Blurry vision
NEUROLOGIC	Headaches Seizures Tremors	Dizziness Numbness Tingling
SKIN	Infection (boils, ulcers, etc) Chronic rashes Acne	Abnormal bruising Excessive hair growth (females) Changes in skin color
PSYCHOLOGICAL	Lack of interest in doing things Feel down, depressed or hopeless	Anxious History of physical violence/abuse

Average hours of sleep each night _____ Is sleep refreshing? Yes No

How would you rate your stress level? **low** 1 2 3 4 5 **high**

How do you cope with daily stressors? _____

Are you currently seeing a mental health professional? Yes No

If yes, please provide name and contact information: _____

List all previous surgeries with date: _____

List your current medications and dosages. Include any vitamins and supplements:

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Do you have any allergies to medications? _____

Continued >

Center for Lifestyle Medicine Initial Assessment (continued)

Preventive care screenings and diagnostic tests you have had (please check and provide the date):

Sigmoidoscopy/Colonoscopy _____

Pap Smear _____

Cardiac Stress Test _____

Mammogram _____

Bone Density _____

Prostate/Testicular Exam _____

Tobacco history (please check): Never Smoked

Past Smoker Current Smoker

Alcohol history (please check): Do Not Drink

Currently Drink _____ drinks per week

Recreational drug use (please check): Never

Past User Present User

FAMILY HEALTH HISTORY:

RELATION	AGE	MEDICAL CONDITIONS	OVERWEIGHT OR OBESE?	AGE AT DEATH
Father				
Mother				
Siblings				
Spouse				
Children				

Continued >

Center for Lifestyle Medicine Initial Assessment (continued)

NUTRITION QUESTIONNAIRE

What one or two things would you like to change about your diet? _____

Do you read food labels? If yes, what do you look for? _____

How confident are you about the *amount* of current nutrition knowledge you have? **low** 1 2 3 4 5 **high**

How confident are you about your ability to *apply* the nutrition knowledge you have? **low** 1 2 3 4 5 **high**

Do you have any food allergies? _____

Do you follow any special diet or dietary restrictions? _____

When and what do you usually eat over the course of a typical day? (Please list in table below):

MEAL	TIME	FOODS EATEN
Breakfast	_____	_____
Snack	_____	_____
Lunch	_____	_____
Snack	_____	_____
Dinner	_____	_____
Snack	_____	_____

What do you drink throughout the day? _____

How many meals per week do you eat in restaurants/order takeout? _____

Do you eat much more rapidly than others? Yes No

Do you eat until feeling uncomfortably full? Yes No

Do you eat large amounts of food when you are not feeling physically hungry? Yes No

Do you feel disgusted with oneself, depressed, or very guilty after overeating? Yes No

Do you eat alone because of being embarrassed by how much you are eating? Yes No

Do you have a history of an eating disorder? (If yes, please check):

Compulsive Overeating Binge Eating Disorder Anorexia Bulimia

Do you feel that you have a food addiction (loss of control over food intake)? Yes No

Continued >

Center for Lifestyle Medicine Initial Assessment (continued)

PHYSICAL ACTIVITY QUESTIONNAIRE

What is the most active thing you do in an average day? _____

What, if any, regular exercise do you participate in and how often? _____

In general, how much do you enjoy doing physical activity? _____

low enjoyment 1 2 3 4 5 **high enjoyment**

What makes it difficult for you to exercise? _____

Do you know any other reason why you should not do physical activity? Yes No

When you exercise or exert yourself, do you have any of the following? (please check if yes)

Shortness of breath Chest pain or pressure Pain in your calves

WEIGHT HISTORY

What was your lowest body weight as an adult? _____ lbs. At what age? _____

What was your highest body weight as an adult? _____ lbs. At what age? _____

Have you previously participated in a commercial or professional weight loss program? Yes No

(If yes, please check all programs):

Weight Watchers Jenny Craig NutriSystem Women's Workout World Very Low Calorie Diet
Weight Loss Medication _____ Other _____
(name of medication)

Have you previously seen a Registered Dietitian (RD)? Yes No

Have you ever had weight loss surgery? If so, which one and when? _____

What is the maximum amount of weight you've lost in the past? _____ lbs.

What are the biggest challenges you face in losing weight/maintaining weight loss? _____

How important is it for you to make lifestyle changes?

very important 1 2 3 4 5 **not important**

How confident are you in your ability to make lifestyle changes?

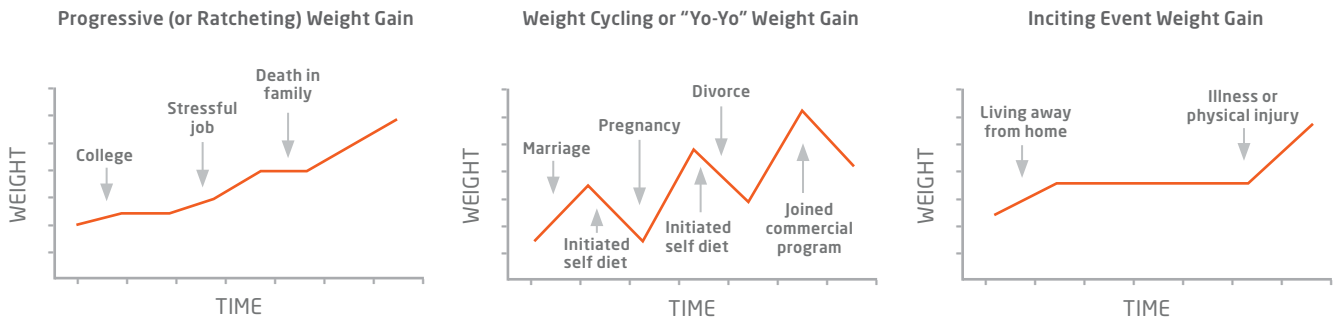
very confident 1 2 3 4 5 **not confident**

Continued >

Center for Lifestyle Medicine Initial Assessment (continued)

Graphing your weight gain

Below are examples of typical weight gain patterns according to life events.



Using the examples as a reference, please graph your weight gain. Mark life events and diet attempts that may have contributed to your current weight.



Continued >

Center for Lifestyle Medicine Initial Assessment (continued)

SIX-FACTOR TRAIT QUESTIONNAIRE (6-FTQ) Please check your level of agreement to all statements:

	Don't agree at all	Agree a little	Agree	Strongly agree
CONVENIENT DINER				
1. I rarely take the time to plan my meals.	0	1	2	3
2. A lot of my meals are eaten in restaurants or taken out.	0	1	2	3
3. Most foods I eat are convenient, ready- made, packaged, frozen or microwavable.	0	1	2	3
4. I eat a fast-food meal on most days of the week.	0	1	2	3
5. I do not have consistent meal patterns from one day to the next.	0	1	2	3
Sub score				
FAST PACER				
6. My fast-paced life leaves me feeling drained and scattered.	0	1	2	3
7. I feel like I'm juggling too many things at once.	0	1	2	3
8. I usually take care of everyone else and put myself at the bottom of my to-do list.	0	1	2	3
9. My hectic schedule makes it hard for me to focus on my health.	0	1	2	3
Sub score				
EASILY ENTICED EATER				
10. I have difficulty controlling my portion sizes.	0	1	2	3
11. I often eat out of habit, not because I am hungry.	0	1	2	3
12. When I'm stressed, lonely, anxious or depressed, I turn to food for comfort.	0	1	2	3
13. If there is food around me, I'll probably eat it.	0	1	2	3
14. I snack throughout the day, hungry or not.	0	1	2	3
15. I will eat until I'm too full - and may even eat more.	0	1	2	3
Sub score				

Continued >

Center for Lifestyle Medicine Initial Assessment (continued)

SIX-FACTOR TRAIT QUESTIONNAIRE (6-FTQ) Please check your level of agreement to all statements:

	Don't agree at all	Agree a little	Agree	Strongly agree
EXERCISE STRUGGLER				
16. Of all things being physically active has never been one of my priorities.	0	1	2	3
17. I don't exercise because frankly I don't like it.	0	1	2	3
18. I never got "into" exercising because I am not sure where to start.	0	1	2	3
19. I have difficulty exercising.	0	1	2	3
Sub score				
SELF-CRITIC				
20. I measure my self-worth by the numbers on the bathroom scale.	0	1	2	3
21. I focus on the things I don't like about my body.	0	1	2	3
22. I make a habit of saying bad things about myself.	0	1	2	3
23. I avoid social situations because of my weight.	0	1	2	3
Sub score				
ALL-OR-NOTHING DOER				
24. I approach my weight loss like it's just another project with a clear beginning and end.	0	1	2	3
25. I'm either on or off my diet - there's no middle ground with me.	0	1	2	3
26. When I'm trying to lose weight, I give 100% of my effort but this is hard to sustain.	0	1	2	3
27. I am all or nothing when it comes to dieting or exercising to lose weight.	0	1	2	3
Sub score				