Weight and Lifestyle Management Program Questionnaire

Personal Information

Last Name_____ Given Name(s) _____ Age _____

Home Address_____

City _____ State _____ Zip _____

Primary Phone _____ Secondary Phone _____

Email _____ Preferred Contact Method_____

Emergency Contact _____ Relationship _____ Phone Number_____

Martital Status

☐ Single ☐ Separated ☐ Married ☐ Long Term Relationship ☐ Common Law ☐ Divorced ☐ Widowed

☐ Other_____

Physicians and Allied Health Professionals

NAME	SPECIALTY	PHONE	FAX

Current Health Problems *(Attach relevant documents and test results if applicable)*

DESCRIPTION	DATE OF ONSET

Past Medical History *(Attach relevant documents and test results if applicable)*

DESCRIPTION	DATE OF ONSET

Past Surgical History and Injuries *(Attach medical documents and test results)*

DESCRIPTION	DATE

Medications and Supplements *(List all prescriptions and supplements)*

NAME	DOSAGE	FREQUENCY	DATE STARTED

Do you have any medication allergies? Please list.

Family History

Mother

☐ Alive Age _____

☐ Deceased Cause of Death_____

Health Concerns:

Father

☐ Alive Age _____

☐ Deceased Cause of Death_____

Health Concerns:

Siblings

# of Brothers _____ # of Sisters _____ Health Concerns _____

Does anybody in your family have a history of... *(List details-who, what age, specific condition, etc.)*

Heart Disease *(Heart Attack, Stroke, Heart Failure, High Blood Pressure, etc.)* _____

Diabetes Types I or II _____

Lipids _____

Thyroid Disease _____

Work History

Highest Level of Education		Current Occupation		Currently Working?
				☐ Yes ☐ On disability ☐ No ☐ Retired
Self Employed?	**Hours Per Day?**	**Hours Per Week?**	**Length of time at current employer**	**Stress Level**
☐ Yes ☐ No				☐ Low ☐ Medium ☐ High ☐ Extreme

Lifestyle Health Behaviors

How would you rate your health in general?

☐ Excellent ☐ Good ☐ Average ☐ Poor

How many hours of sleep do you get each night (on average)?

Weekdays _____ Weekends _____

Do you have any problems falling asleep?

☐ Yes ☐ No

Once asleep, do you have problems staying asleep?

☐ Yes ☐ No

Do you eat breakfast each morning?

☐ Yes ☐ No

Do you eat lunch each day?

☐ Yes ☐ No

On average, how much caffeine do you consume daily? (number of drinks/day)

Coffee _____ Tea _____ Coke/Pop _____

Are you a current smoker?

☐ Yes ☐ No

If yes, how much?

_____

Are you an ex smoker?

☐ Yes ☐ No

If yes, when did you quit? _____

Do you use any illicit drugs?

☐ Yes ☐ No

If yes, which ones? _____

Have you ever had problems with illicit drugs?

☐ Yes ☐ No

If yes, which ones? _____

How much alcohol do you drink on average?

Drinks per day _____

Drinks per week _____

Drinks per month _____

Have you ever had problems with alcohol?

☐ Yes ☐ No

Do you manage stress well?

☐ Yes ☐ No

Describe: _____

How do you manage stress? (check all that apply)

☐ Exercise Description _____

☐ Relaxation Techniques Description _____

☐ Hobbies Description _____

☐ Prayer/Spiritual Activities Description _____

☐ Family Relationships Description _____

☐ Social Relationships Description _____