



**Integrative Weight Loss & Wellness**

5191 S. Yosemite Street Suite B  
Greenwood Village, CO 80126

303-577-9977 Office  
800-592-1505 After

hours

Date: \_\_\_\_\_

Mr. / Mrs./Ms.: \_\_\_\_\_ Age: \_\_\_\_\_

Street Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Sex: M F Date of Birth: \_\_\_\_\_

Marital Status: Single Married Divorced Widowed

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

How did you hear about us?

Referral by \_\_\_\_\_  Advertisement in \_\_\_\_\_

Drive by: \_\_\_\_\_ Other (describe): \_\_\_\_\_



## Medical History

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Allergies to medications (include type of reaction):

\_\_\_\_\_

\_\_\_\_\_

Condition	Yes	No	Condition	Yes	No
Stroke			Insomnia		
Weakness/Paralysis			Headache		
Coronary Heart Disease			Dizziness/Fainting		
High Cholesterol/Lipids			Kidney Disease		
Heart attack			Dialysis		
Chest Pain			Tumor, Cancer (benign or malignant)		
High Blood Pressure			Head Injury		
Pacemaker			Seizure Disorder		
Heart Murmur			Bleeding Disorder		
Shortness of breath			Glaucoma		
Palpitations			Eye/vision problems		
			HIV Infection		
Leg swelling			Recurrent colds/cough		
Reflux/gastritis			Tuberculosis		
Gastric/Duodenal Ulcer			Pregnant?		
Gallbladder Disease			Nursing?		
Intestine problems			Back pain/injury		
Hepatitis/Jaundice			Osteoporosis		
Asthma			Anxiety		
Sleep Apnea			Depression		
Emphysema/COPD			Other Psychiatric Illness		
Pneumonia			History of Anorexia Nervosa or Bulimia		
Diabetes					
If Diabetes, Age at onset:					

Are there any other medical conditions that we should know about? \_\_\_\_\_

\_\_\_\_\_



Do any of your FAMILY MEMBERS (blood relation) have, or have had, any of the following medical conditions or illnesses? (Check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Arthritis        |
| <input type="checkbox"/> Heart Attack             | <input type="checkbox"/> Sleep Apnea      |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Cancer           |
| <input type="checkbox"/> Stroke                   | <input type="checkbox"/> High Cholesterol |

**Medications (please also include over the counter, vitamins & herbal supplements):**

Name of Medication	Dosage	Frequency	Reason for Taking	How Long

Exclusion Medications:

MAOI's (ie. Isocarboxazid (Marplan), Tranylcypromine (Parnate), or Phenelzine (Nardil), Harnaline, Iproclozide, Iproniazid, Nialamide, Selegiline, Tolaxatone in the last 14 days.

Hospitalizations or Surgeries:

Year	Illness or Procedure

Do you use tobacco products:            Yes            No  
 If yes, how much per day and how many years: \_\_\_\_\_

Do you drink alcohol?                    Yes            No  
 If yes, how often: \_\_\_\_\_

Any substance abuse:                    Yes            No            In the past  
 If yes, what type of substance and how often: \_\_\_\_\_



## **Personal Weight Loss Worksheet**

Please answer the following questions regarding past weight loss attempts as well as future goals. This information will help us determine the weight-loss approach that is right for you.

### **Basic Information**

Age: \_\_\_\_\_

How tall are you? \_\_\_\_\_ feet \_\_\_\_\_ inches

How much do you weigh currently? \_\_\_\_\_ lbs

How much did you weigh... 6 months ago? \_\_\_\_\_ 1 year ago? \_\_\_\_\_  
5 yrs ago? \_\_\_\_\_

What has been your maximum lifetime weight (non-pregnant) and when? \_\_\_\_\_

### **Weight-Loss Goals**

How much weight would you like to lose? \_\_\_\_\_

Why would you like to lose the weight? (Check all that apply)

- I'd like to improve my health
- I'd like to look better
- I'd like to get down to a size \_\_\_\_



## **Weight-Loss History**

How do you feel about yourself and your current weight? (Please describe below)

What weight-loss methods have you tried before? (Check all that apply)

- Reduced-calorie diet
- Reduced-carbohydrate diet
- Reduced-fat diet
- Diet programs and support groups
- Physical activity
- Over-the-counter diet pills
- Prescription weight-loss medication
- Herbal remedies

How would you describe your experiences with the weight-loss methods you've listed above? To what extent were they successful and which were successful? (Describe below)

Your level of readiness for weight loss:

- Ready to Take Action
- Ambivalent
- Not Ready

Describe your current types of physical activity as well as past history of exercise patterns:

How often do you engage in physical activities?

- Three or More Times a Week
- Once a Week
- Once or Twice a Month
- Never



I am not able to engage in physical activity for the following reason(s):

Is your spouse/partner overweight?

How would you rate the level of support you can expect from your family and friends?

Do you see any potential barriers to success?

**This information will assist us in establishing your medical management. Thank you for your time and patience in completing this form.**