NORTHERN MICHIGAN WEIGHT LOSS
Affiliated With SECRET FOR WEIGHT LOSS™

Weight Loss Intake and Questionnaire

Date: _____

Full Name: _____ Preferred Name: _____

Sex: ○ Male ○ Female Date of Birth: _____

Age: _____ Height: _____ Weight: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone Number: _____

Email: _____ Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse/Partner's Name: _____

How did you hear about our office? _____ _____

Emergency Contact Name: _____

Emergency Contact Phone number: _____

Emergency Contact Relationship: _____

1. What's the main reason you are seeking treatment at this time?

_____

2. What are your goals about weight control and management?

_____

3. Your level of interest in losing weight is:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not interested Very interested

4. Are you ready for lifestyle changes to be a part of your weight control program?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not interested Very interested

5. How much support can your family provide?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

None Very helpful

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6. How much support can your friends provide?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

None Very helpful

7. What is the hardest part about managing your weight?

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8. What has been your lowest & highest body weight as an adult? Lowest: _____ Highest: _____

9. Please check all previous programs that you have tried in order to lose weight. Indicate dates, length of program, and any medications with respective dose and frequency.

Program	Date/Length	Medication	Dose/Frequency
Weight Watchers			
Liquid Diets			
Keto Diet			
Diet Pills			
Nutrisystem/Jenny Craig			
Obesity Surgery			

10. Have you maintained weight loss for up to 1 yr on any of these programs? ☐ YES ☐ NO

11. What did you learn from these programs regarding your weight?

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12. What did not work about these programs, so we can make changes?

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13. How important is it that you lose weight at this time?

☐ Not ☐ Not Very ☐ Somewhat ☐ Very Important ☐ Imperative

14. How does being overweight affect you?

☐ Limits exercise ☐ Can't wear my clothes ☐ Tired all the time
☐ My knees hurt ☐ My back hurts

15. What is hard about managing your weight?

☐ No will power ☐ I've always been overweight ☐ No exercise
☐ Schedule too busy ☐ Hungry all the time
☐ I don't like vegetables ☐ I'm a meat and potatoes person

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16.What beverages do you drink daily and how much?

Beverage	8oz. Glasses per Day
Water	
Coffee	
Tea	
Soda	
Alcohol	
Other	

17. Would you like to change your eating habits? ☐ YES ☐ NO

18. What habits would you like to begin to change?

19. Is your decision to lose weight your own or for someone else?
☐ Mine ☐ My wife ☐ My husband ☐ My parents ☐ My friends

20. What can't you do now that you would like to do if you weighed less?
☐ Keep up with partner ☐ General activity ☐ Play golf ☐ Go for walks
☐ Play with my children/grandchildren ☐ Get into my old clothes

21. What would you like to get out of this visit regarding your weight?
☐ A diet ☐ Accountability
☐ Understanding about what makes me heavy ☐ Lasting change

22. What's more important to you? INCHES LOST____ POUNDS LOST_____

23. What's more important to you? FAST LOSS_____ PERMANENT LOSS____

24. How much weight do you want to lose? _____
_____

Current Medical Providers: _____
_____

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Medical History

☐Osteoporosis	☐Appendicitis	☐AIDS/HIV	☐Shoulder Pain
☐Heart disease	☐Bleeding disorders	☐Pinched nerve	☐Wrist Pain
☐Diabetes	☐Neck Pain	☐Pneumonia	☐ Elbow Pain
☐Cancer	☐Knee Pain	☐Depression	☐Bulimia
☐Hip Pain	☐Stroke	☐Chemical addiction	☐Psychiatric care
☐Ankle Pain	☐Parkinson's	☐Suicide attempt	☐Fibromyalgia
☐Alcoholism	☐Tumor	☐Multiple Sclerosis	☐Anemia
☐Hepatitis	☐Ulcers	☐Balance Issues	☐Arthritis
☐Hernia	☐Vertigo	☐Anorexia	☐Herniated disc
☐Anxiety	☐High cholesterol	☐Whiplash	☐Sinusitis
☐Migraines	☐Kidney disease	☐Allergies	☐Rheumatoid arthritis
☐Liver disease	☐Herniated Disc	☐Headaches	☐Thyroid problems
☐Low Back Pain	☐TMJ	☐Asthma	☐Pacemaker

Family Health History

☐Osteoporosis	☐ Anorexia/Bulimia	☐ AIDS/HIV	☐ Cancer
☐ Multiple sclerosis	☐ Liver disease	☐ Heart disease	☐ Migraine headaches
☐ Epilepsy	☐ Stroke	☐ Anemia	☐ Rheumatoid arthritis
☐ Diabetes	☐ Thyroid problems	☐ Kidney disease	☐ Tumors
☐ Parkinson's	☐ High cholesterol	☐ Ulcers	☐ Alcoholism

Medication	Dose	Purpose

Signature: _____ Date: _____

Weight Loss OATS–SCORING ASSESSMENT
Impact of Weight on Quality of Life

Name: _____ Date: _____

Trouble bending over
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
never rarely sometimes usually always

Tired or winded
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
never rarely sometimes usually always

Unable to stand comfortably
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
never rarely sometimes usually always

Not physically active
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
not true little true moderately true mostly true always true

Unable to walk far/quickly
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
not true little true moderately true mostly true always true

Uncomfortable in small seats
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
not true little true moderately true mostly true always true

Bodily pain
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
never rarely sometimes usually always

Self-conscious eating in social settings
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
not true little true moderately true mostly true always true

Less confident
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
not true little true moderately true mostly true always true

Feel judged by others
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
not true little true moderately true mostly true always true

Frustrated shopping for clothes
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
not true little true moderately true mostly true always true

Feel bad or upset about pictures of self
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
not true little true moderately true mostly true always true

Down or depressed about weight
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
not true little true moderately true mostly true always true

Less interested in sexual activity
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
not true little true moderately true mostly true always true

Avoid social gatherings
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
never rarely sometimes usually always

Less productive
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
not true little true moderately true mostly true always true

Lack energy
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
never rarely sometimes usually always

Worried about health
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
not true little true moderately true mostly true always true

Self-conscious about weight
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
not true little true moderately true mostly true always true

Frustrated or upset about weight
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
not true little true moderately true mostly true always true

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Initial Re-eval SCORE: _____/100