

## WEIGHT MANAGEMENT HISTORY & INTAKE FORM

Welcome to The Village Medical! We look forward to providing quality medical care for you. In order for us to better serve you, please kindly fill out the information below to the best of your knowledge.

Date (mm/dd/yyyy): \_\_\_\_\_

First Name (nickname if applicable): \_\_\_\_\_

Middle name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ Postal code: \_\_\_\_\_

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

Sex: \_\_\_\_\_ Date of Birth (mm/dd/yyyy): \_\_\_\_\_

Alberta Health Care Number: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Phone number: \_\_\_\_\_ Relationship: \_\_\_\_\_

DEMOGRAPHIC

Your School / Place of work: \_\_\_\_\_

Your Grade / Occupation: \_\_\_\_\_

Marital Status:      Single              Common-Law              Married              Divorced              Widowed

Who lives at home with you? \_\_\_\_\_

SOCIAL HISTORY

Medication Allergy: \_\_\_\_\_ Reaction: \_\_\_\_\_

Medication Allergy: \_\_\_\_\_ Reaction: \_\_\_\_\_

Non-medication Allergy: \_\_\_\_\_ Reaction: \_\_\_\_\_

Do you carry an Epi-Pen?    YES              NO

ALLERGIES

Prescription medications:

MEDICATIONS

Name	Frequency	Dose	Why do you take it?	How long have you been taking it?

MEDICATIONS

Over the counter medications / supplements / vitamins / herbal remedies:

Name	Frequency	Dose	Why do you take it?	How long have you been taking it?

MEDICAL HISTORY

Condition	Year of diagnosis	Do you see a specialist for this	Active or Resolved?

SURGICAL HISTORY

Date of surgery	Type of surgery	Reason for surgery

FAMILY HISTORY

Is there any genetic / hereditary diseases known in your family? YES NO

*i.e. cardiovascular/heart disease, high blood pressure, high cholesterol, diabetes*

Relationship	Condition	Age of diagnosis	Living or Deceased

LIFESTYLE

Do you smoke? YES NO

Cigarettes per day: \_\_\_\_\_

Years of tobacco use: \_\_\_\_\_

Do you drink alcohol? YES NO

Drinks per week: \_\_\_\_\_

Have you / do you use any recreational drugs? YES NO

Marijuana Cocaine Methamphetamine Heroin Other

Do you consume caffeinated beverages (coffee, tea, soda)? YES NO

Drinks per day: \_\_\_\_\_

Present weight: \_\_\_\_\_ lbs Desired weight: \_\_\_\_\_ lbs

Heaviest weight: \_\_\_\_\_ lbs What age? \_\_\_\_\_ years old

Lowest weight: \_\_\_\_\_ lbs What age? \_\_\_\_\_ years old

(maintained for at least 1 year since age 20)

What are your general health goals? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Can you date the onset of your weight concerns to a specific year? YES NO

If yes, what age? \_\_\_\_\_ years old

Do you connect your weight concerns to a specific life event? YES NO

If yes, what was it? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Previous attempts and programs (dietitian, Weight Watchers, Jenny Craig, Overeaters Anonymous, specific diets, weight loss medications, bariatric surgery): \_\_\_\_\_

\_\_\_\_\_

What is your current nutrition education?

- I have a strong and detailed understanding of calories, calorie deficits, portion/serving sizes, macronutrients, micronutrients, etc.
- I have a fair understanding of basic nutrition concepts
- I have minimal/no understanding or background in food and nutrition
- I'm not sure

How would you rate your current relationship with food and your weight?

- I have mostly positive associations
- I have neutral associations
- I have some negative associations
- I have mostly negative associations
- I'm not sure

Over the last 6 months, have you been prevented from exercising because of health limitations or restrictions?            YES      NO

If yes, please describe (*i.e. overweight, arthritis/joint pain, fracture/sprain, asthma, heart issues*):

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What is your typical energy level?

- Excellent
- Good
- Fair
- Poor

What is your typical physical activity level?

- Inactive:** *no regular physical activity with a sit-down job.*
- Light activity:** *no organized physical activity during leisure time.*
- Moderate activity:** *occasional activities such as weekend golf, tennis, jogging, swimming or cycling.*
- Heavy activity:** *consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least 3 times per week.*
- Vigorous activity:** *extensive physical exercise for at least 60 minutes per session 4 times per week.*