

IV4U HYDRATION LOUNGE

Medical Weight Loss Program Intake Form

Patient Name: (Last) (First) (MI)

Patient Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Birthdate: _____ Age: _____ Sex: M F Height: _____ Weight: _____

Occupation: _____ Medication allergies: _____

In Case of Emergency:

Name: _____ Relationship: _____

Phone: _____

How did you hear about us? _____

Are you under the care of a qualified healthcare professional? Please list whom. *

As detailed in the Consent portion, it is highly recommended that you are under the care of a qualified healthcare professional, who has verified that it is safe for you to exercise and be on a weight loss program and is monitoring medications and any health concerns that you list here (besides your weight issues- that's what we're covering). If you are on medications (particularly for high blood pressure, heart issues or diabetes), you will need these to be monitored during and after the program as your need for them may change. *

I acknowledge the above statement. Sign: _____

Medical History

Please list any medical conditions a medical provider has diagnosed you with in the past (such as high blood pressure, diabetes, PANCREATITIS, THYROID CANCER, etc...): *

LIST medications, supplements and/or any over the counter items you take regularly or are currently prescribed: *

Any past surgeries / hospitalizations? *

Please describe your family history in terms of heart disease, diabetes, obesity, high cholesterol, high blood pressure, and cancer (THYROID):

Personal History

Are you currently pregnant? Y/N Date of LMP? _____

What are your main interests and hobbies?

Do you exercise regularly? Please detail.

What kind of other movement or activities do you enjoy?

How is your energy?

Does your energy level affect your daily activities?

How would you describe your mood, generally:

How would you describe your stress level?

What are your sources of stress?

How do you manage stress?

Do you have people close to you who support you?

Diet and lifestyle

Do you regularly drink alcoholic beverages? Y/N; If yes, how many drinks per week?_____

Do you smoke tobacco? Y/N

Do you use recreational drugs? Y/N

How is your appetite? _____

Snack Habits/cravings:

What:

How much:

When:

Typical Breakfast:

What:

How much:

When:

Typical Lunch:

What:

How much:

When:

Typical Dinner:

What:

How much:

When:

How often do you eat out?

What restaurants do you frequent?

How often do you eat "fast foods"?

Do you drink coffee or tea? Yes / No If Yes, how much daily?

Do you drink sugary drinks? If yes, how much?

Do you use sugar substitutes?

What are your worst food habits?

How much WATER do you normally drink/day? Please approximate in ounces.

Please list any food allergies, intolerances or foods you avoid and the reason.

What past struggles and difficulties have you experienced in terms of food and dieting? Do you eat because of emotions (explain)?

What diet and exercise programs, protocols, plans or approaches have you tried in the past and did they work?

And what hasn't worked for you at all?

When did you first become overweight?

How did your weight gain start? Describe any circumstances:

What do you think is the cause of your weight problem?

What was your highest weight? (excluding pregnancy)

What was your lowest weight?

Have you ever stayed the same weight for 10 years or more?

How **MOTIVATED** are you to lose weight?

Is there anything else you would like to tell us?

Please list the factors you feel have contributed to your current weight (check all that apply):

Slow metabolism

☐

Family history of
obesity

☐

Comfort food dependency	<input type="text"/>
Lack of exercise	<input type="text"/>
Binge eating	<input type="text"/>
Late night snacking	<input type="text"/>
History of trauma	<input type="text"/>
History of grief and loss	<input type="text"/>
Medication related weight gain	<input type="text"/>
Significant restrictive eating behaviors like anorexia	<input type="text"/>

Please answer the following questions to the best of your knowledge:

Health History *

	No, never	Yes, currently	Not currently, but within the last year	Not currently and longer than 1 year ago
Fatigue	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Unexplained weight loss or gain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Change in appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depressive symptoms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mood swings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nervousness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Addictive dependency	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Disordered Eating Pattern/ Tendency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of mental focus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood sugar irregularities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive thirst or hunger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar cravings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal hair growth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive perspiration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling excessively hot or cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lightheadedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain or stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle weakness or soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur/palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold or pale extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Short of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal discomfort after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Belching/gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daily bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>