

New Patient Questionnaire (Health Care Analysis)

Today's Date: _____

First Name:	Last Name:	Email:		
_____	_____	_____		
Address:		City:	State:	Zip Code:
_____		_____	_____	_____
Home Phone:	Work Phone:	Cell Phone:	Date of Birth:	
_____	_____	_____	_____	
Age:	Height:	Weight:	Gender:	
_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	
How did you hear about us?:		If referred by someone, who?:		
_____		_____		

Please answer the following questions honestly so we can do our best to help you reach your goals

Who encouraged you to lose weight?: _____

How important to you is it to lose weight?: _____

What important reason, special occasion, or goal date do you have to lose weight?: _____

How many pounds would you like to lose?: _____ How fast do you want lose the weight?: _____

Would you commit to one visit a week?: Yes No

Have you ever attended any other weight reduction centers, if so, which ones?: _____

What kinds of diets have you tried on your own?: _____

What is the longest you have been able to stick with a diet?: _____

Does your family support your weight loss efforts?: Yes No

Have you been advised by your family physician to lose weight?: Yes No

If you answered Yes, what is your doctor's name?: _____

Do you eat because of emotions?: Yes No

If you answered yes, please explain: _____

Food and Chemical Sensitivity

Please complete the following survey using the key below

- = No symptoms (0 points)
- = Mild symptoms (1 point)
- = Moderate symptoms (2 points)
- = Severe symptoms (3 points)

Weight:

- Inability to lose weight
- Food cravings
- Binge eating
- Nausea or vomiting
- Water retention

Digestive Symptoms:

- Stomach pains or cramping
- Constipation
- Diarrhea
- Reflux or heartburn
- Bloating
- Gas

Head and Ears:

- Migraines
- Headaches
- Earaches
- Wheezing
- Ear infection
- Ringing in ears

Eyes and Throat:

- Itchy eyes
- Watery eyes
- Sore throat
- Persistent canker sores

Sinus and Respiratory:

- Stuffy or runny nose
- Asthma
- Chest congestion
- Chronic cough
- Frequent sneezing

Skin Disorders:

- Dermatitis
- Excessive sweating
- Rashes
- Hives
- Eczema

Emotional and Mental:

- Depression
- Anxiety
- Mood swings
- Irritability
- Poor concentration

Energy:

- Fatigue
- Lethargy
- Restlessness
- Insomnia
- Hyperactivity

Other Symptoms:

- Joint pain
- Arthritis
- Irregular heartbeat
- Chest pains
- Muscle aches

OFFICE USE ONLY
Total Points: <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/>
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