Inside Out Weight Loss Program

Initial Evaluation Form

Circle One: Employee Spouse Child SAP#_____

(All questions MUST be answered. Patients are NOT chosen on a first-come, first- served basis. The information you provide will NOT impact your health insurance. Only Allegiance Health Insurance patients can qualify.)

Name _____ Date of Birth _____ Age _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Occupation _____

Current Weight _____ Current Height _____ Sex: □ Male □ Female

At what age did you begin to develop a significant weight problem? _____

In your **opinion**, what contributes to your excess weight?

□ Portion sizes □ Eating too much fat and sugar □ Stress eating

□ Emotional eating □ Compulsive eating □ Lack of exercise

□ Medications (please list below) □ Lack of knowledge about healthful eating and exercise

Please describe any events you believe are related to your weight gain

_____

Lowest weight as an adult (and when)? _____ **Peak** adult weight (and when)? _____

Other significant weight **gain**? _____ Other significant weight **loss**? _____

Activity growing up: Involved in sports/athletics? □ Yes □ No

Which Sports/Activities? _____

Did your family have dinner together? □ Yes □ No

□ Meat & Potatoes □Pasta □Fried Food □ Fast Food Dessert □ Yes □ No

How many meals do you consume per day? _____

How many snacks do you consume per day? _____

Any food Intolerances, food allergies, food restrictions, special diet? Please list.

Current medications and supplements

Name	Dose	How often	Start Date	Vitamin/Mineral	OTC (Aspirin, etc)	OTC (Herbal)

Please list allergies to medications and your reaction

_____

_____

Current lifestyle

Please check the appropriate box:

□ Single □ Married □ Divorced □ Widow □ Significant Other

Do you live alone? □ Yes □ No

Do you have children? □ Yes □ No If yes, please list ages _____

Do your children live at home? □ Yes □ No □ N/A

Do you smoke? □ Yes □ No

If yes, number of packs per day _ number of years __When did you quit _____

Do you drink alcohol? ___How many drinks/day ____How often _____

Do you use illicit drugs? □ Yes □ No

If yes, please describe drug, method and frequency of use (e.g. IV, smoke, snort, etc) _____

Do you currently exercise regularly? □ Yes □ No

If yes, what exercise do you perform?_____

How many times per week? _____How long do you exercise each time? _____

Weight Loss History

If treatment was recommended, what have you tried in the past?

□ Lifestyle □ Medication □ Surgery

Lifestyle (Diet and Exercise)

Name of Program	Year Started	How long?	Start Weight	# of lbs lost	Time wt stayed off	# of lbs regained

Weight Loss Medications (Prescription, Over-the-counter, Herbal)

Name of Program	Year Started	How long?	Start Weight	# of lbs lost	Time wt stayed off	# of lbs regained

Have you had nutrition counseling? ☐ Yes ☐ No

If yes, please describe _____

Personal Medical History

□ Heart Disease □ Diabetes □ Sexual Dysfunction □ Kidney Disease

□ High Blood Pressure □ GI Disorder □ Polycystic Ovarian Syndrome □ Bariatric Surgery

□ High Cholesterol □ Gout □ Anemia (Gastric bypass, Lap Band)

□ Sleep Apnea □ Arthritis □ Clotting/Bleeding Disorder

□ Asthma □ Osteoporosis □ Cancer

□ Thyroid Disorder □ Urinary Incontinence □ Other _____

Are you currently on a diet for a medical reason? □ Yes □ No

Have you ever had surgery? □ Yes □ No

Please list ALL **surgical** procedures and the approximate date: _____

_____

_____

Are you receiving any psychiatric/psychological services at this time? □ Yes □ No

If yes, by whom_____

Are you currently being treated for depression? □ Yes □No

If yes, by whom _____

Have you ever been diagnosed with an eating disorder? □Yes □ No

If yes, please describe _____

Binge Eating and Purging (Please check the appropriate box to your response)

Aside from holiday feasts, have you ever eaten a large amount of food rapidly and felt that this eating incident was excessive and out of control afterward? □ Yes □ No

If you answered yes to the above question, how often have you engaged in this behavior during the last year? Please check one.

1. Less than once a month
2. About once a month
3. A few times a month
4. About once a week
5. About three times a week
6. Daily

Have you ever purged (used laxatives, diuretics, or induce vomiting) to control your weight?

□ Yes □ No

If you answered yes to the above question, how often have you engaged in this behavior during the last year? Please check one.

1. Less than once a month
2. About once a month
3. A few times a month
4. About once a week
5. About three times a week
6. Daily

Please feel free to use this space for any additional information.

_____

_____

What do you feel your weight may be holding you back from doing?

Approx. How much weight would you like to lose to help reach your goals?

Inside Out Weight Loss Program

COLLIER COUNTY MEDCENTER AGREEMENT

I, _____ (patient's full name), give the medical provider at the Collier County Med Center authority to work as an adjunct with my current Primary Care Physician in managing my medical care. This includes, but is not limited to, modifying my current medications as seen fit based on regular blood draws during the duration of the weight loss program.

_____ (patient's signature)

_____ Date (mm/dd/year)

_____ (provider's signature)

_____ Date (mm/dd/year)

Fill out & Bring to Physical Wellness Visit

General Medical History & Information

Are you under the care of a physician, chiropractor, or other health care professional for any reason?

If yes, list reason:_____

Are you aware of any disease or disorder that would complicate your participation in a testing or exercise program?_____

Has your doctor ever told you that you have a bone or joint problem that has been or could be made worse by exercise?_____

Are you taking any medications? If yes please indicate the type of medication, dosage, frequency and reason(s) for taking it. _____

Please list any allergies_____

Has your doctor ever said your blood pressure was too high? _____

Are you over age 65? _____ Are you unaccustomed to vigorous exercise? _____

Is there any reason not mentioned here why you should not follow a regular exercise program?
If so, please explain _____

Please describe any past or current musculoskeletal conditions you have incurred such as muscle pulls, sprains, fractures, surgery, back pain, or general discomfort:

Head / Neck _____

Upper Back _____

Shoulder / Clavicle _____

Arm / Elbow _____

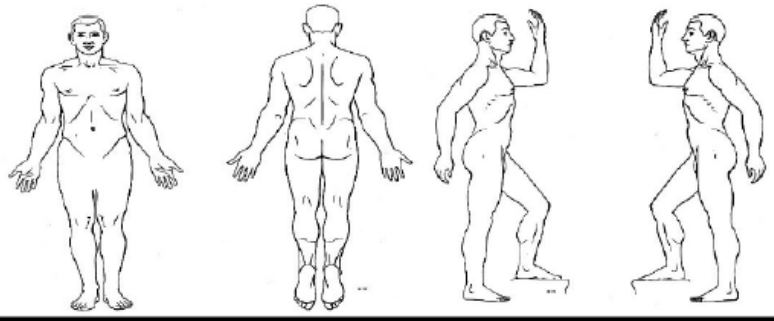
Wrist / Hand _____

Lower Back _____

Hip / Pelvis _____

Thigh / Knee _____

Lower Leg / Ankle / Foot



Please circle any areas of pain, injury, tension, or restriction of movement.

Have you recently experienced any chest pain associated with either exercise or stress?
If so, please explain _____

Do you have a family history of any of the following conditions?

Heart Disease _____ Heart Attack _____ Hypertension _____ Gout _____

Abnormal EKG _____ Asthma _____ High Cholesterol _____ Angina _____

Diabetes _____ Other heart conditions _____

Do you have a family history of cardiovascular disease? If so, how many occurrences and what approximate ages? _____

Are you a smoker? If so, what is your smoking frequency? _____

Are you on any specific food / nutritional plan at this time? _____

Do you take dietary supplements? If yes, please list _____

_____

How many beverages do you consume per day that contains caffeine? _____

Do you experience any frequent weight fluctuations? _____

Have you experienced a recent weight gain or loss? _____

If yes, list change _____ Over how long? _____

Your answers to these questions will be discussed with you prior to your session. Thank You.

Body Type / Activity Level / Goal Information

What are your goals? (Circle those that apply)

Body Fat Loss Muscle Gain Strength Production Increase Flexibility General Health Maintenance

How active are you and/or what is your exercise lifestyle like? (Circle those that apply)

Sedentary Moderate Exercise Competitive Exercise Bodybuilding

Does your job require you to be….. (Circle those that apply)

Sedentary Somewhat Active Active Very Active

Please answer yes or no to the following questions:

Is it hard for you to gain weight?
Can you eat a lot and still not gain weight?
Do you gain or lose weight according to your fluctuations in activity and food consumption?
Is it hard for you to lose weight?
Do you gain weight if you're not careful about food intake?

Current Nutritional Consumption

Please list the foods, beverages, supplements etc that you take on the average day.

Time / Qty / Food-Beverage-Supplement

Bring Food Diary to Nutrition Appt

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6
Breakfast						
Snack						
Lunch						
Snack						
Dinner						
Desserts						
Beverages						

Fill out & Bring to Nutrition Appt

1) Is there a reason you are seeking weight loss program?

2) What are your goals about weight control & management?

3) Your level of interest in losing weight

1 2 3 4 5

Not interested Very Interested

4) Are you planning to adopt lifestyle changes as part of your weight control program?

1 2 3 4 5

No Yes

5) How much support does your family provide you to reach your weight loss goals?

1 2 3 4 5

No support Much Support

6) How much support do your friends provide?

1 2 3 4 5

No support Much support

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

8) What do you believe will be the most to help you lose weight?

9) How confident are you that you can lose weight at this time?

1 2 3 4 5

Not confident Very Confident