OnPointe MEDICAL CENTER

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:** ☐ **Male** ☐ **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: _____

_____

_____

_____

What is most important to you in deciding to use our services? (Please check all that apply):

- ☐ Effectiveness “My results are my top priority.”
- ☐ Time “I want results quickly.”
- ☐ Service “I need extra support along the way.”
- ☐ Ease “I have a difficult time losing weight.”

I understand that my patient file will be kept completely confidential unless I give written permission for my information to be released.

_____ _____

Signature: **Date:**

Notes:

On average, which of the following reflects your daily eating habits? (Please check all that apply):

- ☐ 3 meals with healthy snacks
- ☐ 3 meals
- ☐ 2 meals or less
- ☐ Skip breakfast or other meals
- ☐ Generally eat on the run
- ☐ No regular eating pattern
- ☐ Often crave sweets/carbs
- ☐ Graze; small, frequent meals (How many per day? _____)

Current level of exercise (Please check one that applies):

- ☐ None
- ☐ Light exercise (1-3 times per week, easy pace, stretching, walking, etc.)
- ☐ Moderate exercise (2-3 times per week, moderate pace, some weights, etc.)
- ☐ Heavy exercise: (3-4 times per week, vigorous pace, weights, fast running, etc.)

Health Information

Past or Present Health Conditions (Please check all that apply):

- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Strokes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Hormone Imbalance
- ☐ Hormonal Cancer
- ☐ Thyroid Imbalance
- ☐ Anorexia
- ☐ Bulimia
- ☐ Drug Addiction
- ☐ Currently pregnant or nursing
- ☐ Allergic to sulfur, food or medication
- ☐ Vegetarian

If you checked any of the above, please explain: _____

_____

Have you ever been hospitalized, under medical care, or checked into rehab for alcohol or drug treatment?: ☐ Yes ☐ No

If you answered yes, please explain: _____

_____

Please list all medications you are currently taking, including doses and reasons for taking

Medication:	Dose:	How often:	Reason:	Prescribing M.D.

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Symptom Survey

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

Hormone:

☐ ☐ ☐ ☐ Irregular cycle
☐ ☐ ☐ ☐ Menopausal symptoms
☐ ☐ ☐ ☐ Weight gain
☐ ☐ ☐ ☐ Hair loss
☐ ☐ ☐ ☐ Depression/ anxiety
☐ ☐ ☐ ☐ Mental fuzziness
☐ ☐ ☐ ☐ Memory problems
☐ ☐ ☐ ☐ Fatigue
☐ ☐ ☐ ☐ Decreased libido
☐ ☐ ☐ ☐ Aggression
☐ ☐ ☐ ☐ Hot flashes and/or night sweats

Head and Ears:

☐ ☐ ☐ ☐ Migraines
☐ ☐ ☐ ☐ Headaches

Emotional and Mental:

☐ ☐ ☐ ☐ Depression
☐ ☐ ☐ ☐ Anxiety
☐ ☐ ☐ ☐ Mood swings
☐ ☐ ☐ ☐ Irritability
☐ ☐ ☐ ☐ Poor concentration

Skin Conditions:

☐ ☐ ☐ ☐ Acne /acne scars
☐ ☐ ☐ ☐ Sagging skin
☐ ☐ ☐ ☐ Fine lines and wrinkles
☐ ☐ ☐ ☐ Loss of volume
☐ ☐ ☐ ☐ Enlarged pores
☐ ☐ ☐ ☐ Lip lines

Hair Conditions:

☐ ☐ ☐ ☐ Hair loss
☐ ☐ ☐ ☐ Thinning hair
☐ ☐ ☐ ☐ Receding hair

Muscle & Joint:

☐ ☐ ☐ ☐ Arthritis
☐ ☐ ☐ ☐ Foot trouble
☐ ☐ ☐ ☐ Low back pain
☐ ☐ ☐ ☐ Neck pain or stiffness
☐ ☐ ☐ ☐ Pain between shoulders
☐ ☐ ☐ ☐ Headaches
Pain or numbness in:
☐ ☐ ☐ ☐ Shoulders
☐ ☐ ☐ ☐ Arms
☐ ☐ ☐ ☐ Elbows
☐ ☐ ☐ ☐ Hips
☐ ☐ ☐ ☐ Legs
☐ ☐ ☐ ☐ Knees
☐ ☐ ☐ ☐ Sciatica

Energy:

☐ ☐ ☐ ☐ Fatigue
☐ ☐ ☐ ☐ Lethargy
☐ ☐ ☐ ☐ Restlessness
☐ ☐ ☐ ☐ Insomnia
☐ ☐ ☐ ☐ Hyperactivity

Other Symptoms:

☐ ☐ ☐ ☐ Irregular heartbeat
☐ ☐ ☐ ☐ Chest pains
☐ ☐ ☐ ☐ Muscle aches

Please list any symptoms you experience that were not previously mentioned: _____