Name: _____ **Date:** _____

INTAKE FORM

Oregon Medical Weight Loss & Wellness

Best phone number to reach you _____ Email address _____
Social Security Number _____ Age _____ D.O.B._____
Address_____ City_____State_____Zip_____
Primary Care Provider_____ Occupation_____
What is your preliminary goal weight?_____
Current Marital Status (circle one): Single Engaged Married Separated Divorced Widowed Domestic Partner
Is your immediate family or friend group supportive of your weight loss efforts? YES NO
What is your main reason for deciding to lose weight now? _____
List activities you are **not** doing now, but would **like** to do in the future _____
When did you begin gaining excess weight? (Give reasons if known) _____
_____
What has been your maximum lifetime weight (non-pregnant) and when? _____
Has your weight changed in the last 2-3 months? _____
Any history of eating disorders, now or in the past? Please explain _____
_____
What are your expectations of us (your medical team)? Be specific: _____
_____

Previous diets you have followed	Dates	Results of your weight loss	Any weight regained?

Which was you best "diet success" and why did it work well for you? _____
_____

How often do you eat out or eat "fast foods"? _____
In your household, who plans meals? _____ Cooks? _____ Shops? _____
Is your spouse or partner overweight? YES NO If so, approximately how much?_____
Foods you crave? _____
What are your worst food habits? _____
Please describe your snack habits _____
Do you think alcohol plays a part in your weight gain or makes it harder for you to lose weight? YES NO
Do you awaken hungry or eat during the night? YES NO
Do you feel you are an emotional eater? YES NO Please list circumstances that trigger this emotional eating behavior_____
Have you used appetite suppressants in the past? YES NO If so, which ones? _____
What were the results? _____

INTAKE FORM

Oregon Medical Weight Loss & Wellness

Typical Breakfast	Typical Lunch	Typical Dinner

Please list any conditions, illnesses, or treatments that might be relevant to your visit today _____

_____

Do you feel you are in good health at the present time? YES NO If not, why? _____

Are you under any other doctor's care at the present time? If yes, who? (and for what)_____

_____

Do you drink sodas? YES NO How much daily? _____

Do you use a sugar substitute? YES NO How much daily? _____

Do you drink alcohol? YES NO How much daily/weekly? _____

Do you drink coffee or tea? YES NO How much daily? _____

Smoking Habits

___ I have never smoked cigarettes, cigars, or a pipe.

___ I quit smoking _____ years ago and have not smoked since.

___ I quit smoking at least one year ago and now smoke cigars or a pipe w/out inhaling smoke.

___ I smoke approx _____cigarettes per day (_____ pack/s)

Medication Allergies?_____ Food Allergies?_____

If so, what is your reaction? _____

Please list all prescription medications you are taking at the present time

Drug	Dosage	Taken for what reason?

Any over-the-counter medications, vitamins, herbs, supplements or natural remedies? _____

Have you had a bariatric surgery? YES NO When? _____ What type?_____

Please list all serious injuries and surgeries you have experienced:

Serious injury/surgery	Date

Name: _____ **Date:** _____

INTAKE FORM

Oregon Medical Weight Loss & Wellness

Check ALL the weight related Risks or Diagnoses that you may have:

Gastrointestinal
- ☐ Abdominal Pains
- ☐ Constipation
- ☐ Diarrhea
- ☐ Elevated Liver Enzymes
- ☐ GERD or heartburn
- ☐ Irritable Bowel Syndrome
- ☐ Nausea
- ☐ Reflux
- ☐ Ulcers
- ☐ Vomiting

Psychiatric
- ☐ Anorexia Nervosa (now or past)
- ☐ Anxiety
- ☐ Binge Eating patterns/disorder
- ☐ Bulimia/Purging (exercise, laxatives, vomiting, diuretics)
- ☐ Depression/dysthymia
- ☐ Panic Attacks

Endocrine
- ☐ Diabetes
- ☐ Pre-diabetes
- ☐ Gestational Diabetes
- ☐ High Blood Pressure
- ☐ "Pre-Hypertension"
- ☐ High Cholesterol
- ☐ Menopause
- ☐ Triglycerides
- ☐ Painful, heavy, or irregular menses
- ☐ Cushing's Syndrome
- ☐ Polycystic Ovarian Syndrome
- ☐ Thyroid Disorder:
  - ☐ High ☐ Low

Musculoskeletal
- ☐ Arthritis
- ☐ Muscle Spasm
- ☐ Gout
- ☐ Hip pain
- ☐ Knee pain
- ☐ Lower back pain
- ☐ Plantar Fasciitis
- ☐ Osteoporosis
- ☐ Osteopenia

Other
- ☐ Abnormal EKG
- ☐ Anemia
- ☐ Asthma
- ☐ Breast Cancer
- ☐ Decreased Libido
- ☐ Dizziness
- ☐ Eating in the middle of the night
- ☐ Fatigue
- ☐ Fibromyalgia
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Insomnia
- ☐ Low Blood Sugars
- ☐ Low Testosterone
- ☐ Migraines
- ☐ Psoriasis
- ☐ Seizures/Traumatic Brain Injury
- ☐ Sleep Apnea
  - ☐ Using CPAP
- ☐ Snoring
- ☐ Swelling feet or ankles
- ☐ Urinary Stress Incontinence
- ☐ Vitamin D Deficiency

Family History

Has any blood relative had any of the following:

Early death:	YES	NO	Who: _____	Age of death: ____
			Cause _____	
Epilepsy:	YES	NO	Who: _____	Age of diagnosis: ____
High Blood Pressure:	YES	NO	Who: _____	Age of diagnosis: ____
Kidney Disease:	YES	NO	Who: _____	Age of diagnosis: ____
Diabetes:	YES	NO	Who: _____	Age of diagnosis: ____
Psychiatric Disorder:	YES	NO	Who: _____	Age of diagnosis: ____
Heart Attack:	YES	NO	Who: _____	Age of diagnosis: ____
Heart Disease:	YES	NO	Who: _____	Age of diagnosis: ____
Stroke:	YES	NO	Who: _____	Age of diagnosis: ____
Overweight/Obesity:	YES	NO	Who: _____	Age of diagnosis: ____
Glaucoma:	YES	NO	Who: _____	Age of diagnosis: ____

OB/Gynecologic History (Women only)

Number of Pregnancies: _____ Vaginal Delivery or C-Section: _____

Babies over 9 lbs? YES NO If yes what were their weights? _____

Menstrual Onset: _____ yrs old Duration: _____ days Last menstrual period: _____

Do you have pain associated with menstrual cycle? YES NO Are menses heavy? _____

Are you on Birth Control? YES NO If yes, please list: _____

On Hormone Replacement Therapy? YES NO If yes, please list: _____

When was your last Physical/ PAP? _____

INTAKE FORM

Oregon Medical Weight Loss & Wellness

Behavioral Health

When you are in a stressful situation that is work or family related, do you tend to eat more or less? Explain.

_____

Are you currently undergoing any stress or emotional upset? Explain. _____

Are you currently experiencing suicidal thoughts? _____

Have you seen a mental health provider for services? Explain._____

Have you ever been hospitalized for psychiatric, drug, or alcohol addiction? YES NO

Date _____ Hospital _____ Diagnosis _____

Please check all that apply to you currently:

- ☐ Stress
- ☐ Unhappiness
- ☐ Inferiority feelings
- ☐ Fears
- ☐ Depression
- ☐ Anger
- ☐ Racing thoughts
- ☐ Friends
- ☐ Impulsive behavior
- ☐ Ambition
- ☐ Finances
- ☐ Panic
- ☐ Apathy
- ☐ Hopelessness
- ☐ Alcohol use
- ☐ Temper
- ☐ Physical abuse
- ☐ Problems concentrating
- ☐ Loss of control
- ☐ Sexual problems
- ☐ Death
- ☐ Pregnancy
- ☐ Making decisions
- ☐ Parenting
- ☐ Unwanted thoughts
- ☐ Abortion
- ☐ Shyness
- ☐ Communication
- ☐ Sexual abuse
- ☐ Bad dreams
- ☐ Marriage
- ☐ Trauma/disaster
- ☐ Trouble with job
- ☐ Children
- ☐ Nervousness
- ☐ Emotional abuse
- ☐ Anxiety
- ☐ Guilt
- ☐ Grief
- ☐ Loneliness
- ☐ Memory loss
- ☐ Compulsivity
- ☐ Legal matter

Activity Level (answer only one)

___ **Inactive/ Sedentary** - includes only the light physical activity associated with typical day-to-day life

___ **Moderate Activity** - includes physical activity equivalent to walking about 1.5 to 3 miles per day at 3 to 4 miles per hour (in addition to the light physical activity associated with typical day-to-day life)

___ **Active** - includes physical activity equivalent to walking more than 3 miles per day at 3 to 4 miles per hour, (in addition to the light physical activity associated with typical day-to-day life)

Please indicate your level of **motivation to lose weight** on the scale below:

0	**5**	**10**
Unmotivated	**Neutral/Unsure**	**Very Motivated**

Do you have any interest in getting more information about how the other specialties in our clinic may enhance or assist you in your weight loss?

- ☐ Mental Health/Counseling
- ☐ Physical Therapy
- ☐ Massage Therapy
- ☐ Acupuncture

Name: _____ **Date:** _____

INTAKE FORM

Oregon Medical Weight Loss & Wellness

Sleep Questionnaire

Please check any of the following symptoms you are experiencing:

- ☐ Difficulty falling asleep and/or insomnia
- ☐ Excessive daytime sleepiness and/or fatigue
- ☐ Snoring
- ☐ Has any bed partner noticed you not breathing while asleep, waking up gasping or choking?
- ☐ Interrupted sleep patterns
- ☐ Sleepiness while driving
- ☐ Frequent morning headaches
- ☐ Migraines
- ☐ Hypertension
- ☐ Diabetes
- ☐ High cholesterol
- ☐ Obesity
- ☐ Ear pain
- ☐ Neck pain
- ☐ Depression and/or anxiety
- ☐ Teeth grinding and/or clenching
- ☐ Leg movements/restless legs

Have you already been previously diagnosed with sleep apnea or another sleep related disorder? YES NO

If so, how was your condition diagnosed and what treatment did you receive? _____

If you are using a CPAP device, how often do you use it?

Circle one: every night / almost every night / sometimes / infrequently / never

EPWORTH SLEEP QUESTIONNAIRE

How likely are you to doze off or fall asleep in the following situations?

Never = 0 Slight = 1 Moderate = 2 High = 3

	NEVER chance of dozing	SLIGHT chance of dozing	MODERATE chance of dozing	HIGH chance of dozing
Sitting and reading				
Watching TV				
Sitting inactive in a public place (e.g. a theater or a meeting)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a lunch without alcohol				
In a car, while stopped for a few minutes in traffic				

Total Score: _____

Staff only

BMI: _____ (Risk if >30)

Neck circumference: _____ (Risk if: Male > 16.5 in., Women > 15 in.)

INTAKE FORM

Oregon Medical Weight Loss & Wellness

Mood Assessment Checklist

Elevated Mood?	Not all all.....Extremely 0	1	2	3	4
I have much more energy than usual	☐	☐	☐	☐	☐
I feel unusually euphoric and "high"	☐	☐	☐	☐	☐
I am irritable and short-tempered	☐	☐	☐	☐	☐
I have a heightened interest in sex	☐	☐	☐	☐	☐
My thoughts are speeded up (or racing)	☐	☐	☐	☐	☐

Difficulty Sleeping?	Not all all.....Extremely 0	1	2	3	4
I have trouble getting to sleep	☐	☐	☐	☐	☐
I wake repeatedly during the night	☐	☐	☐	☐	☐
I awaken too early in the morning	☐	☐	☐	☐	☐
I've gone for days with nearly no sleep	☐	☐	☐	☐	☐
I sleep more than eight hours each night	☐	☐	☐	☐	☐

Depressed Mood?	Not all all.....Extremely 0	1	2	3	4
I feel sad, blue, or downhearted	☐	☐	☐	☐	☐
I have feelings of helplessness	☐	☐	☐	☐	☐
I have crying spells (or feel like it)	☐	☐	☐	☐	☐
I feel hopeless about the future	☐	☐	☐	☐	☐
I've lost interest or pleasure in things	☐	☐	☐	☐	☐
I have low energy level	☐	☐	☐	☐	☐
I feel guilty or worthless or both	☐	☐	☐	☐	☐
My appetite has increased (or decreased)	☐	☐	☐	☐	☐
My memory has gotten bad	☐	☐	☐	☐	☐
It has become hard to concentrate	☐	☐	☐	☐	☐

Social Anxiety?	Not all all.....Extremely 0	1	2	3	4
I am uncomfortable in social situations	☐	☐	☐	☐	☐
I am intimidated by people in authority	☐	☐	☐	☐	☐
I fear embarrassing myself in public	☐	☐	☐	☐	☐
I get panicky when in social situations	☐	☐	☐	☐	☐
I avoid going to parties	☐	☐	☐	☐	☐
I avoid being the center of attention	☐	☐	☐	☐	☐
Being criticized scares or angers me	☐	☐	☐	☐	☐
I avoid having to give speeches	☐	☐	☐	☐	☐
I'd do anything to avoid being criticized	☐	☐	☐	☐	☐
Talking to strangers scares me	☐	☐	☐	☐	☐

Thoughts of Suicide?	Not all all.....Extremely 0	1	2	3	4
I often wish I were dead	☐	☐	☐	☐	☐
Others would be better off without me	☐	☐	☐	☐	☐
I think about various ways to end my life	☐	☐	☐	☐	☐
I've settled on a specific plan for suicide	☐	☐	☐	☐	☐
I have decided to commit suicide	☐	☐	☐	☐	☐

Obsessive Features?	Not all all.....Extremely 0	1	2	3	4
I tend to worry excessively	☐	☐	☐	☐	☐
I tend to be a perfectionist	☐	☐	☐	☐	☐
I do tasks slowly to insure accuracy	☐	☐	☐	☐	☐
I fret about germs & contamination	☐	☐	☐	☐	☐
It is often hard to make decisions	☐	☐	☐	☐	☐

Vegetative Features?	Not all all.....Extremely 0	1	2	3	4
I sleep too much	☐	☐	☐	☐	☐
I am often in bed or on the couch	☐	☐	☐	☐	☐
My housekeeping has deteriorated	☐	☐	☐	☐	☐
I spend most of my time alone	☐	☐	☐	☐	☐
My personal hygiene has fallen off	☐	☐	☐	☐	☐

Compulsive Features?	Not all all.....Extremely 0	1	2	3	4
I tend to check and re-check things	☐	☐	☐	☐	☐
I bite my nails, or pull at my hair	☐	☐	☐	☐	☐
I wash my hands or bathe excessively	☐	☐	☐	☐	☐
I need to count things repeatedly	☐	☐	☐	☐	☐
I must keep things neat and clean	☐	☐	☐	☐	☐

Agitated Features?	Not all all.....Extremely 0	1	2	3	4
I pace, fidget, or an unable to sit still	☐	☐	☐	☐	☐
I have been irritable or cranky	☐	☐	☐	☐	☐
I yell at or argue with family or others	☐	☐	☐	☐	☐
I am having outbursts of anger	☐	☐	☐	☐	☐
I have thoughts of harming others	☐	☐	☐	☐	☐

Distressing or Peculiar Thoughts?	Not all all.....Extremely 0	1	2	3	4
People are watching or talking about me	☐	☐	☐	☐	☐
Others are aware of my private thoughts	☐	☐	☐	☐	☐
I hear voices that others do not hear	☐	☐	☐	☐	☐
I see things that are not really there	☐	☐	☐	☐	☐
Someone else can control my thoughts	☐	☐	☐	☐	☐

Panic Anxiety?	Not all all.....Extremely 0	1	2	3	4
Episodes of intense fear or a sense of "impending doom"	☐	☐	☐	☐	☐
During these episodes I have the following:					
Palpitations, pounding, or fast heart rate	☐	☐	☐	☐	☐
Sweating, trembling, or shaking	☐	☐	☐	☐	☐
Shortness of breath / smothered feeling	☐	☐	☐	☐	☐
Chest pain or discomfort	☐	☐	☐	☐	☐
Feeling dizzy, lightheaded, or faint	☐	☐	☐	☐	☐
Fear of losing control or of dying	☐	☐	☐	☐	☐
Numbness, tingling, or feeling of unreality	☐	☐	☐	☐	☐
Chills or hot flushes or nausea	☐	☐	☐	☐	☐
Persistent concern about more attacks	☐	☐	☐	☐	☐