Nourished MedSpa and Wellness Center
Weight Loss Patient Information

Date: _____ Name: _____ Date of Birth: _____

WEIGHT HISTORY

Current Weight _____

Desired Weight _____

Highest Weight (excluding pregnancy) _____, Your age then? _____

Lowest Weight (excluding pregnancy) _____, Your age then? _____

Have you ever stayed the same weight for 10 years or more? Yes □ No □

How did your weight gain start? Describe any circumstances: _____

_____

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

_____

DIET HISTORY

Have you attempted to lose weight before? Yes □ No □
If yes, what is the most weight you lost? _____ How long did it take? _____

Which of the following methods of weight loss or dietary restriction have you tried (or currently on)?

□ Vegetarian diet	□ Vegan diet	□ Low calorie diet
□ Intermittent fasting diet	□ Body for Life diet	□ Nutrisystem
□ Jenny Craig	□ Weight Watchers	□ Atkins Diet
□ South Beach diet	□ Ketogenic diet	□ Liquid diet (juice fast)
□ Blood-type diet	□ Low-fat diet	□ Low glycemic-index diet
□ Macrobiotic diet	□ Mediterranean diet	□ Raw foods diet
□ Organic foods diet	□ Low-protein diet	□ Low-sodium diet
□ DASH diet	□ Gluten-free diet	□ Lactose free diet

Do you eat 3 meals/day? Yes □ No □

If not, how many? _____

Which meals do you commonly miss? _____

Do you graze throughout the day? Yes □ No □

How many times/week do you eat out or pick something up to bring home? _____

Are you a nighttime eater? Yes □ No □
If so what do you normally eat? _____

Are you a binge eater? Yes □ No □

History of purging after you binge? Yes □ No □
If yes, are you purging through exercise, vomiting, laxatives, or diuretics? _____

Do you do the majority of the grocery shopping? Yes □ No □

Do you or other people think you eat too fast? Yes □ No □

Do you cook at home? Yes □ No □

Is your spouse, fiancée or partner overweight? Yes □ No □

Do you have any overweight children? Yes □ No □

If you are a vegetarian, what foods will you not eat?_____

Have you used weight loss medications in the past? Yes □ No □
If yes Name:_____

If you have taken weight loss medication in the past, how long ago did you take it?_____

If you have taken weight loss medication did you experience side effects? Yes □ No □
If yes, please explain_____

If you have taken weight loss medication in the past, how much weight did you lose?_____

Do you drink coffee? Yes □ No □ How much? _____

Do you drink regular soda pop? Yes □ No □ How much? _____

Do you drink diet soda pop? Yes □ No □ How much? _____

Do you crave/eat sugar & carbohydrates Yes □ No □ This is a problem for me □

Do you exercise? Yes □ No □
If yes, how often and what kind? _____

What time do you normally first put some type of food in your mouth?_____

What time do you normally finish eating/snacking before going to bed at night? _____

Do you experience chronic pain? Yes □ No □

Do you have any autoimmune disorders? Yes □ No □
If yes, what? _____

Do you smoke? Yes □ No □
Are you often exposed to chemicals? Yes □ No □ _____

How much purified water do you drink per day? □ little to none □ with meals □ at least half my body weight in oz

Regarding sleep: □ I get enough sleep and feel rested upon waking □ I have difficulty falling asleep □ I wake up and can't get back to sleep □ I have broken sleep □ I have difficulty getting up and moving in the morning

Activity Level: **(answer only one)**

- □ Inactive—no regular physical activity with a sit-down job.
- □ Light activity—no organized physical activity during leisure time.
- □ Moderate activity—occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
- □ Heavy activity—consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week.
- □ Vigorous activity—participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

Think about your weight and honestly answer how it is affecting your life in each of the following places:

Work/Productivity:
□ Increases □ Decreases □ Doesn't Affect

Energy Levels:
□ I'm Vibrant □ I'm Tired □ I'm Exhausted □ Doesn't Affect

Sleep:
□More Rested □ Less Rested □ Doesn't Affect

Mood:
□ I'm Happier □ I'm More Irritable □ Doesn't Affect

Hobbies/Sports:
□ Improves Performance & Enjoyment □ Negatively Affects □ N/A

Social Life:
□ Makes me More Social □ I'd Rather Stay Home □ Doesn't Affect

Intimacy:
□ Improves it □This is a Problem □ Doesn't Affect

Family Life:
□ Enhances it □ Negatively Effects □ Doesn't Affect

Marriage:
□ Enhances it □ Source of Strain in my marriage □ Doesn't Affect

How motivated are you to lose weight now? _____ (0-None, 10-very motivated)

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or complications from your treatment that may be irreversible and/or dismissal from the practice. The treatments I receive here are voluntary and I release this institution, all employees and contractors from liability and assume full responsibility thereof.

_____ Date: _____

Patient Signature

Patient Initial_____