WEIGHT LOSS CONSULTATION FORM

Client Name: MRN:

Do you have any food or drug allergies? _____

PAST MEDICAL HISTORY

Please check any of the following you have ever had:

Heart Issues	Stroke	Depression	Anxiety/ADD/ADHD	Bipolar
Bulimia	Anorexia	Pancreatitis	High Blood Pressure	Diabetes
Thyroid Issues	Glaucoma	MEN-2	Medullary Thyroid Cancer	Seizures

Please list any other past or present medical conditions not listed above:

_____

_____

SURGICAL HISTORY

Surgery	Date

Have you ever had weight loss surgery? Yes No If Yes, date of procedure:_____

If yes to above, Highest Pre-Surgery Weight:_____ Lowest Post Surgery Weight:_____

FAMILY HISTORY

Condition	Family Member

CURRENT MEDICATIONS

Medication	Dose	Frequency	What For?

WEIGHT LOSS CONSULTATION FORM

WEIGHT HISTORY

Height:_____ Current Weight:_____ Highest Weight:_____ Desired Weight:_____

At what age did you first start having a weight problem?_____

Has weight come on gradually over the years or suddenly?_____

Have you ever been able to lose weight and keep it off? ☐ Yes ☐ No

If No to the above, how quickly did it return? _____

Have you recently lost or gained any weight? ☐ Yes ☐ No

If Yes, what worked for you? _____

NUTRITION HISTORY

How many meals do you eat each day? _____

How many snacks do you eat each day? _____

Do you graze?_____ How many times a week do you eat fast food? _____

Cups per day of caffeinated beverages consumed (coffee, tea, soda, energy drinks) _____

Check all of the factors that apply to your eating habits and current lifestyle

☐ Love to eat ☐ Emotional Eater ☐ Late Night Eater ☐ Fast Eater

☐ Bored Eater ☐ Shift Worker ☐ Eat too much ☐ Fast Foods often

☐ Poor Snack choices ☐ Nutrition Label Confusion ☐ Different Family Tastes ☐ Travel/time Constraints

LIFESTYLE INFORMATION

What is your Physical Activity Level (check one): ☐ Very ☐ Mild ☐ Light ☐ Sedentary

How often do you exercise per week (check one): ☐ Daily ☐ 2-3 Times ☐ None

What type of exercise do you do (check one): ☐ Cardio ☐ Weight ☐ HIIT ☐ Combination

Do you get good sleep ☐ Yes ☐ No

What do you like to do to relieve stress? _____

What is your occupation?_____

Have you experienced any of these major stressors in the last year (Check all that apply):

☐ Serious Injury ☐ Family/Friend Death ☐ Divorce/Separation ☐ Gain of New Family Member

☐ Job Change ☐ Major Illness Self or Family

Please check any that you currently use: ☐ Tobacco ☐ Alcohol ☐ Recreational Drugs

WHAT DIET PROGRAMS IF ANY, HAVE YOU USED IN THE PAST

Program	Weight Loss?

WEIGHT LOSS CONSULTATION FORM

PAST MEDICATIONS USED TO LOSE WEIGHT (CHECK ALL THAT APPLY)

Medication	Was it effective	Did you have side effects?	When did you take it?
Phentermine (Adipex, Lomaira)			
Tenaute (Diethylpropion)			
Belviq (Lorcaserin)			
Contrave (Naltrexone, Bupropion)			
Qsymia (Phentermine/Topiramate)			
Saxenda (Liraglutide)			
Xenical (Orilstat Prescription)			
Ally (Orlistat -Over the counter)			
Topamax (Topiramate)			
Glucophage (Metformin)			
Victoza/Saxenda (Liraglutide)			
Meridia (Sibutramine)			
Phen/Fen or Fenfluramine			
Ozempic/Wegovy (Semaglutide)			

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the practitioner or other health professional of my current medical health conditions and to update this history. A current medical history is essential for the practitioner to execute appropriate treatment procedures, I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Client Name (Print):_____

Client Signature:_____ Date:_____