Weight Loss Questionnaire

Name _____ Home Phone _____

Address _____ Work Phone _____

City_____ State_____, Zip_____ Cell Phone_____

Birth date_____ Age _____ SS#_____ Male_____ Female_____

Occupation Employer _____

Employer's Address_____Phone # _____

Marital Status: M W Sep. D Sin. Spouse Name_____ No. of Children _____

Spouse's Employer _____

Spouse's Birth date: _____ E-mail Address _____

1. Most patients are referred to our office by a caring family member or friend.

What made you decide to visit our office?
☐ Friend/Family Member Name ☐ Telephone Call ☐ Yellow Pages ☐ Sign ☐ Website ☐ Presentation ☐ E-mail

2. When was your last physical?_____ ☐ Never

3. Stress can slow weight loss and even cause weight gain. Rate your stress level over the last 90 days.
Low - 1 2 3 4 5 6 7 8 9 10 - High

4. Please list any health symptoms or health complaints you are experiencing.

1._____

2._____

3._____

5. Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking?

6. Is there any chance that you are pregnant? ☐ YES ☐ NO

7. Have you ever been diagnosed with cancer? ☐ YES ☐ NO Type_____Year _____

8. Do you have an implanted medical device such as a pacemaker? ☐ YES ☐ NO

9. When was your last complete spinal examination including X-rays? ☐ Never

10. If the doctor feels that our weight loss program would benefit you, are you willing to follow his/her recommendations?
☐ YES ☐ NO

All of the above patient information is true and accurate to the best of my knowledge.

Patient Signature _____ Date _____