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NCWH Weight Management Program: *Be Happy in Your Own Skin*

INTAKE INFORMATION

Date:_____

Name:_____

Date of Birth:_____ Number of Children:_____

Occupation:_____

Personal Goal with this Program:_____

Current Weekly Exercise:_____

_____

Current Stress Level (circle one): none / low / med / high

Current Nicotine use: (circle one): none / occassionally / weekly / daily / a problem

Current Sleep Schedule: _____

Other Drug use: (type and frequency) _____

Current TV/ Computer/Screen time (hours/week) _____

Have you ever been Diagnosed with an Eating Disorder? If yes, please describe:

_____

Any Food Restrictions: _____

Please List Previous or Current Medical Conditions: _____

_____

Please List Previous Surgeries: _____

_____

Current Medications:_____

_____

Allergies to Medications:_____

_____

Your Most Important Reasons for wanting to Change Your Health Climate is:

_____

_____

Have you ever had Medullary Thyroid Cancer or Pancreatitis? Y / N

Do you have a History of Diabetes? Y / N – High Blood-Pressure? Y / N – Heart Disease? Y / N