



**1. Please enter your information.**

First Name: \_\_\_\_\_ Middle Initials: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
 Female  Male  Single  Married  Domestic Partner  
 Separated  Divorced  Widowed

Address: \_\_\_\_\_ Apt./Unit #: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Preferred contact method: \_\_\_\_\_  
 Mobile Phone  Home Phone  Work Phone  
 Email

Emergency Contact and phone # \_\_\_\_\_ Your Profession \_\_\_\_\_

**2. Are you currently under the care of a family physician or any other health professional? If yes, please indicate:**

	Health professional's name	Health professional's contact	Condition
1			
2			

**3. Are you allergic to any medications or foods?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**4. Please list any prescribed medications you take:**

	Name	Dosage
1		
2		

5. Please list all non-prescription medications you take:

	Name	Dosage
1		
2		

6. Have you been diagnosed with any of the following conditions?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Heart condition        |
| <input type="checkbox"/> Cancer                          | <input type="checkbox"/> Bleeding disorder  | <input type="checkbox"/> Hypothyroid            |
| <input type="checkbox"/> Irritable bowel                 | <input type="checkbox"/> Ulcerative colitis | <input type="checkbox"/> Hyperthyroid           |
| <input type="checkbox"/> Asthma                          | <input type="checkbox"/> HIV / AIDS         | <input type="checkbox"/> Osteoporosis           |
| <input type="checkbox"/> Rheumatoid arthritis            | <input type="checkbox"/> Kidney disease     | <input type="checkbox"/> Cardiovascular disease |
| <input type="checkbox"/> Heart Attack                    | <input type="checkbox"/> Angina             | <input type="checkbox"/> High Blood Pressure    |
| <input type="checkbox"/> Gall Stones/Gall Bladder issues | <input type="checkbox"/> Sleep Apnea        | <input type="checkbox"/> Stroke                 |
| <input type="checkbox"/> Liver Disease                   | <input type="checkbox"/> Reflux/GERD        | <input type="checkbox"/> Gout                   |
| <input type="checkbox"/> High Cholesterol                | <input type="checkbox"/> Celiac Disease     | <input type="checkbox"/> Pancreatitis           |
| <input type="checkbox"/> PCOS                            | <input type="checkbox"/> Infertility        | <input type="checkbox"/> Other(s)               |
| <input type="checkbox"/> Eating Disorder                 | <input type="checkbox"/> None               |   |

If "other(s)", please specify

---

7. List any past surgeries:

---



---



---



---

8. What medical tests or investigations have you had recently? (Include reason for test and results)

---



---



---



---

**9. General: Do you have any of the following symptoms?**

Fatigue

Fever

Weakness

Weight Gain/Loss

Trouble Sleeping

Snoring

Apneic times when asleep

**10. On a scale of 1 to 10 indicate where your energy levels are currently:**

Energy levels:

1  2  3  4  5  6  7  8  9  10

**11. Skin health: Do you have any of the following symptoms or conditions?**

Eczema

Psoriasis

Skin cancer

Dermatitis

Hives

Itchy skin or body

Acne

Rash

Other(s)

None

If "other(s)", please specify

---

**12. Head: Do you have any of the following symptoms?**

Headache

Head Injury

Aneurysms

Headaches/Migraines

Other(s)

None

If "other(s)", please specify

---

**13. Ear health. Do you have any of the following symptoms?**

Recurrent ear infections

Tinnitus (ringing ears)

Hearing problems

Ear Drainage

Other(s)

None

If "other(s)", please specify

---

**14. Eye health. Do you have any of the following symptoms?**

Blurry Vision

Glasses/Contacts

Glaucoma

Cataracts

Red eyes

Itchy eyes

Dry eyes

Flashing Lights

Other(s)

None

**If "other(s)", please specify**

---

**15. Nose health: Do you have any of the following symptoms?**

Hay fever (allergic rhinitis)  
(seasonal or all year round?)

Frequent nose bleeds

Nasal polyps

Discharge

Sinus Pain

Other(s)

None

**If "other(s)", please specify**

---

**16. Throat Health: Do you have any of the following symptoms?**

Dry Mouth

Bleeding Gums

Dentures

Sore Throat

Hoarseness

Ulcers

Thrush

Other(s)

None

**If "other(s)", please specify**

---

**17. Neck Health: Do you have any of the following symptoms?**

Lumps

Pain

Stiffness

Swollen Glands

Other(s)

None

**If "other(s)", please specify**

---

**18. Endocrine: Do you have any of the following symptoms?**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Hot Flashes<br>_____      | <input type="checkbox"/> Night Sweats<br>_____      | <input type="checkbox"/> Dry and Wrinkled Skin<br>_____      |
| <input type="checkbox"/> Hair falling out<br>_____ | <input type="checkbox"/> Cold all the time<br>_____ | <input type="checkbox"/> Swelling all over the body<br>_____ |
| <input type="checkbox"/> Other(s)<br>_____         | <input type="checkbox"/> None<br>_____              |  |

**19. Breast Health: Do you have any of the following symptoms?**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Lumps<br>_____                   | <input type="checkbox"/> Discharge<br>_____         | <input type="checkbox"/> Pain/Breast Tenderness<br>_____ |
| <input type="checkbox"/> Currently breastfeeding<br>_____ | <input type="checkbox"/> Perform self exam<br>_____ | <input type="checkbox"/> Other(s)<br>_____               |
| <input type="checkbox"/> None<br>_____                    |   |  |

If "other(s)", please specify

---

**20. Respiratory Health: Do you have any of the following symptoms?**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Cough<br>_____  | <input type="checkbox"/> Shortness of Breath<br>_____ | <input type="checkbox"/> Wheezing<br>_____ |
| <input type="checkbox"/> Sputum<br>_____ | <input type="checkbox"/> Other(s)<br>_____            | <input type="checkbox"/> None<br>_____     |

If "other(s)", please specify

---

**21. Cardiovascular health: Do you have any of the following symptoms?**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> High blood pressure<br>_____ | <input type="checkbox"/> Low blood pressure<br>_____     | <input type="checkbox"/> High cholesterol<br>_____         |
| <input type="checkbox"/> Chest pain<br>_____          | <input type="checkbox"/> Heart palpitations<br>_____     | <input type="checkbox"/> Varicose veins<br>_____           |
| <input type="checkbox"/> Cold hands and feet<br>_____ | <input type="checkbox"/> Swollen feet or ankles<br>_____ | <input type="checkbox"/> Palpitations on exertion<br>_____ |
| <input type="checkbox"/> Other(s)<br>_____            | <input type="checkbox"/> None<br>_____                   |  |

If "other(s)", please specify

---

**22. Gastrointestinal Health: Do you have any of the following symptoms?**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Heartburn<br>_____    | <input type="checkbox"/> Nausea/Vomiting<br>_____ | <input type="checkbox"/> Diarrhea<br>_____        |
| <input type="checkbox"/> Constipation<br>_____ | <input type="checkbox"/> Jaundice<br>_____        | <input type="checkbox"/> Rectal Bleeding<br>_____ |
| <input type="checkbox"/> Bloating<br>_____     | <input type="checkbox"/> Other(s)<br>_____        | <input type="checkbox"/> None<br>_____            |

If "other(s)", please specify

---

**23. Urinary Health: Do you have any of the following symptoms?**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Urinary incontinence<br>_____     | <input type="checkbox"/> Frequent urination<br>_____   | <input type="checkbox"/> Pain urinating<br>_____            |
| <input type="checkbox"/> Difficulty urinating<br>_____     | <input type="checkbox"/> Incomplete urination<br>_____ | <input type="checkbox"/> Sudden urgency to urinate<br>_____ |
| <input type="checkbox"/> Urine leakage when cough<br>_____ | <input type="checkbox"/> Other(s)<br>_____             | <input type="checkbox"/> None<br>_____                      |

If "other(s)", please specify

---

**24. Genital: Do you have any of the following symptoms?**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Pain with sex<br>_____       | <input type="checkbox"/> Discharge<br>_____ | <input type="checkbox"/> Erectile Dysfunction<br>_____ |
| <input type="checkbox"/> Sores<br>_____               | <input type="checkbox"/> Itching<br>_____   | <input type="checkbox"/> Vaginal Dryness<br>_____      |
| <input type="checkbox"/> Decreased Sex Drive<br>_____ | <input type="checkbox"/> Other(s)<br>_____  | <input type="checkbox"/> None<br>_____                 |

If "other(s)", please specify

---

**25. Musculoskeletal: Do you have any of the following symptoms?**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Joint Pain<br>_____ | <input type="checkbox"/> Stiffness<br>_____ | <input type="checkbox"/> Back Pain<br>_____ |
| <input type="checkbox"/> Trauma<br>_____     | <input type="checkbox"/> Other(s)<br>_____  | <input type="checkbox"/> None<br>_____      |

If "other(s)", please specify

---

**26. Neurological: Do you have any of the following symptoms?**

Seizures

Dizziness

Fainting

Vertigo

Numbness/Tingling

Weakness

Other(s)

None

If "other(s)", please specify

---

**27. Psychiatric: Do you have any of the following symptoms?**

Nervousness

Depression

Memory Loss

Stress

Anxiety

Mental Confusion/Foggy Brain

Mood Changes/Irritability

Tension

Other(s)

None

If "other(s)", please specify

---

**28. Preconception care**

Are you and your partner planning on becoming pregnant in the next 6 months?

---

Have you and your partner been having difficulty becoming pregnant? If applicable, how long have you been trying?

---

**29. Please tick the boxes which indicate ailments that have affected your relatives and specify to which relative (s) the ailments apply :**

Anxiety

Breast Cancer

Colon Cancer

Cancer

Depression

Diabetes

Epilepsy

Gout

Heart Disease

High Cholesterol

Thyroid Issues

None

**30. When did you become overweight?**

Childhood

Teens

Adulthood

Pregnancy

Menopause

**Further explanation**

---

**31. Have you gained more than 20 pounds within 3 months in your lifetime?**

Yes

No

**Further Explanation if needed**

---

**32. How much did you weigh 1 year ago?**

---

**33. How much did you weigh 5 years ago?**

---

**34. How much did you weigh 10 years ago?**

---

**35. What are your situational or behavior triggers for weight gain?**

Stress

Marriage

Divorce

Illness

Medication Abuse

Travel

Injury/Surgery

Work

Insomnia

Quit smoking/alcohol

Anger/Depression

Reward Seeking

Boredom

Parties/Social Events

none

**Further Explanation**

---

**36. What are your food triggers associated with cravings or weight gain?**

Eating Out

Fast Food

Sugar

Carbs

Salt

none

**List any triggers not listed above:**

---

**37. What other previous weight loss programs have you tried:**

- |   |                                      |   |
|---|--------------------------------------|---|
| <input type="checkbox"/> Weight Watchers  | <input type="checkbox"/> Nutrisystem | <input type="checkbox"/> Medifast       |
| <input type="checkbox"/> Ideal Protein    | <input type="checkbox"/> Jenny Craig | <input type="checkbox"/> Atkins         |
| <input type="checkbox"/> South Beach Diet | <input type="checkbox"/> Paleo       | <input type="checkbox"/> Ketogenic Diet |
| <input type="checkbox"/> HCG              | <input type="checkbox"/> none        |   |

Please list other(s)

---

**38. Which medications below have you tried for weight loss in the past:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Phentermine/Adipex | <input type="checkbox"/> Meridia              | <input type="checkbox"/> Xenical/Alli            |
| <input type="checkbox"/> Phen-Fen           | <input type="checkbox"/> Topiramate/Topamax   | <input type="checkbox"/> Phendimetrazine/Bontril |
| <input type="checkbox"/> Saxenda            | <input type="checkbox"/> Bupropion/Wellbutrin | <input type="checkbox"/> Belviq                  |
| <input type="checkbox"/> Qsymia             | <input type="checkbox"/> Contrave             | <input type="checkbox"/> Diethylpropion/Tenuate  |
| <input type="checkbox"/> none               |   |  |

Any issues with the medications?

---

**39. How many times a day do you eat and do you skip meals?**

---

---

---

---

**40. How many days per week do you workout: Duration of Exercise:**

---

---

---

---

**41. What kinds of exercise do you enjoy:**

- |  |                                   |   |
|--|-----------------------------------|---|
| <input type="checkbox"/> Running/Jogging | <input type="checkbox"/> Weights  | <input type="checkbox"/> Exercise Classes |
| <input type="checkbox"/> Boot Camp       | <input type="checkbox"/> Swimming | <input type="checkbox"/> Elliptical       |
| <input type="checkbox"/> Other Cardio    |                                   |   |

List any other exercises

---

42. What prevents you from working out?

---

---

---

---

43. Your habits:

	How much?	How often?
Smoking		
Alcohol		
Recreational drugs		
Tea		
Coffee		
Sleeping pills		
Laxatives		

44. How many hours sleep a night do you get on average and do you feel like you are rested in the morning?

---

---

---

---

45. How did you hear about our clinic?

- Internet Search                       Yelp                                       Friend/Family  
 Facebook                               Instagram                               Other

Name of Family/Friend-

---