Patient Name _____

Weight-loss Intake Form
Initial Visit

PATIENT INFORMATION

Name: _____ Date: _____

Birth Date: _____ Age: _____ Weight:_____lbs Height:_____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Mobile Phone: _____

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed ○ Other _____

Preferred Pharmacy: _____ Phone: _____

Occupation: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Primary Care Physician: _____ Office Phone: _____

Would you like to authorize Sozo Integrative Health to have permission to speak to the individual named below about your treatment? By giving the information below you are giving us permission to speak with the individual about your treatment.

Name: _____ Relationship: _____ Phone: _____

MOTIVATIONS & GOALS

What is your main reason for weight loss treatment? *Check all that apply:*
□ I want this for myself ("self-motivation").
□ A family member insisted that I lose weight.
□ My physician has recommended weight loss.
□ Other_____

What is your motivation for weight loss treatment? *Check all that apply:*
□ To improved appearance.
□ To be more active.
□ To have a better quality of life.
□ To improve in my health conditions.
□ Other_____

Overall Goals:
□ No weight goal, only to feel better.
□ No weight goal, improvement in _____
□ Weight goal of _____ lbs

WEIGHT HISTORY

Normal weight during childhood? □ Yes □ No
Highest adult weight_____ lb / Lowest adult weight_____ lb
Please describe when and how you started gaining weight.

_____
_____
_____
_____
_____

Is there evidence of a genetic history of obesity? *Check all that apply:*
□ There is a strong family history of obesity.
□ Obesity started early and has been progressive during my life.

Are there any other reasons for weight gain? *Answer any that apply.*
Shift work with associated weight gain of_____lb
I quit smoking with associated weight gain of_____lb
Past or present medications associated with weight gain of _____lb

Female patients only:
I have post-partum weight retention of_____lb
I have menopause associated weight gain of_____lb

DIET HISTORY

What diets have worked for you in the past? *Please list all that apply.*

_____
_____
_____
_____

What is the most weight that you have lost _____ lbs
How long did you maintain your weight loss? _____
Are you currently working with a Registered Dietitian? □ Yes □ No If No, would you like to? □ Yes □ No

Please write down everything you ate in the previous 24 hours starting with *yesterday morning.*
(*Please include alcohol and sugar-free beverages as well.)*

Meal	Time	Food and Drinks Consumed
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

Do you have excessive hunger within 1-2 hours of having a regular meal? □ Yes □ No

At times I eat when I am not hungry. □ Yes □ No
If yes, describe when this happens and why?

_____

I eat for comfort when I am stressed or emotional. □ Yes □ No
If yes, describe when this happens and why?

_____

There are times when I eat, and it feels like I can't stop. □ Yes □ No
If yes, describe when this happens and why?

_____

I try to manage my weight by vomiting, using laxatives, diuretics, or excessive exercise. □ Yes □ No
If yes, when was the last time?

_____

I eat late at night, or I wake up at night and eat. □ Yes □ No

Please list foods that you eat frequently.

_____

_____

PHYSICAL ACTIVITY HISTORY

At work I am? □ Constantly moving □ Somewhat active □ Not active
I exercise regularly. □ Yes □ No

Type of exercise that I usually do: _____

Amount of time I exercise: _____ minutes.

Number of times I exercise in a week? _____

I have been unable to exercise because?

_____

The physical activities I enjoy include?

_____

Other activities that are limited by my weight:

_____

Would you be interested in working with an exercise specialist to help guide your exercise to assist with weight loss? □ Yes □ No

SLEEP HISTORY

I sleep an average of _____ hours. I go to sleep at _____ am/pm and wake up at _____ am/pm.

I wake up _____ times a night for _____ My last drink of the day is at _____.

I have been diagnosed with Obstructive Sleep Apnea (OSA): □ Yes □ No
I currently use a CPAP or other device for OSA: □ Yes □ No
You may SKIP if already diagnosed with OSA.

1. I snore loudly: □ Yes □ No
2. I feel tired, fatigued, or sleepy during the daytime: □ Yes □ No
3. I have been observed me stop breathing, gasp, or chock when I sleep: □ Yes □ No
4. I have a diagnosis or are treated for high blood pressure: □ Yes □ No
5. My BMI is > 35: □ Yes □ No
6. My age is >50: □ Yes □ No

STRESS/MOOD HISTORY

My stress level during the past year on a scale of 1 to 10: _____
When I feel stressed, I tend to?

_____

The main cause of my stress is?

_____

_____

Any thoughts about harming yourself or wanting to die:	□ Yes	□ No
Have you been to the ER or hospitalized for mental health reasons:	□ Yes	□ No
Any alcohol or substance abuse, including prescription abuse:	□ Yes	□ No

MEDICAL HISTORY

History of High Blood Pressure?	□ Yes	□ No
History of High Cholesterol?	□ Yes	□ No
History of Coronary Artery Disease?	□ Yes	□ No
History of Heartburn?	□ Yes	□ No
History of Asthma/COPD/Emphysema?	□ Yes	□ No
History of Joint Pain?	□ Yes	□ No
History of Gastroparesis?	□ Yes	□ No
History of Gall Bladder disease?	□ Yes	□ No
History of Pancreatitis?	□ Yes	□ No
Personal or family history of thyroid cancer?	□ Yes	□ No
History of Thyroid Disease?	□ Yes	□ No
History of Diabetes?	□ Yes	□ No
History of Cancer?	□ Yes	□ No
History of Multiple Endocrine Neoplasia?	□ Yes	□ No
History of Fatty Liver?	□ Yes	□ No

Female patients only:
Date of last period _____ Current contraceptive/Birth control use: _____

Current Medication List & Allergies

Drug Allergies / Reactions:

_____

_____

Current Medications & Dose:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Current Supplements

_____ _____ _____

_____ _____ _____

HABITS

I exercise _____ times a week

Type(s) of exercises: _____ Duration (mins): _____

I use E-cigarettes / Vapes:	□ No	□ Yes, _____ times per day
I smoke cigarettes / cigars:	□ No	□ Yes, _____ times per day
I use Marijuana:	□ No	□ Yes, _____ times per day
I drink alcoholic beverages:	□ No	□ Yes, _____ drinks per day / week
I use caffeine:	□ No	□ Yes, _____ times / cups per day

FAMILY HISTORY / RELATION

		Relation
Hypertension	□ No	□ Yes, _____
Diabetes	□ No	□ Yes, _____
Coronary Artery Disease	□ No	□ Yes, _____
Cancer/Type	□ No	□ Yes, _____
Other		_____

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. These policies have been our standard practice for years.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services, www.hhs.gov.

We practice the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes several vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM

Print Name: _____

Signature: _____ Date: _____