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Clinical Intake Assessment

Name _____ Date _____

Date of Birth_____ Age _____ Sex: F M Racial/ethnic group: _____

Best way to reach you:_____

Present Health Status:

Please rate your overall health: (circle a number)

1 2 3 4 5 6 7 8 9 10

Very Unhealthy Very Healthy

What physical symptom, current health problem or other, has prompted your interest in getting help with managing your weight?

How many times in the last year have you met with a physician for treatment of these symptoms or clinical problems (List any procedures, consultations that you have had include dates)?

What do you **hope to achieve** in this program?

How **important** is it to you to make lifestyle changes? Very important 1 2 3 4 5 Not important

How **confident** are you about making these changes? Very confident 1 2 3 4 5 Not confident

Social:

Occupation: Work hours? Travel for work? Night shift?

Relationship status: Regarding my relationship status, I am: very satisfied 1 2 3 4 5 dissatisfied

List the people in your household and their relationship to you:

Do you have someone to turn to for emotional support?

How do you spend your evenings after work and weekends?

Do you have any hobbies or interests?

Date of last physical exam:

Please indicate the date of the last time you were tested and results for the following:

Cardiac Stress test:	Mammogram:	Flexible sigmoidoscopy or Colonoscopy:	
Testicular/Prostate Exam:	Gyn/PAP:	Bone Density:	
Blood Pressure:	Blood sugar:	Cholesterol:	Liver function:

Please list any **surgical procedures** (including biopsies) or hospitalizations that you may have had and **when**:

Have you ever had any of the following? [**Circle** all that apply and indicate **date of onset** and if it is a **current problem**]

_____Sleep disorders: insomnia, sleep apnea (CPAP?), snoring, sleep walking,

_____High blood pressure, swelling in legs (edema),

_____Diabetes (pre-diabetes, glucose intolerance, insulin resistance, gestational)

_____High Cholesterol (abnormal triglycerides, high LDL, low HDL)

_____Stroke, TIAs, fainting, dizziness, syncope

_____Heart disease (heart attack, murmur, rhythm problems, stent, bypass)

_____Chest pressure, pain, tightness or shortness of breath on exertion or normal activity

_____Gall bladder disease or gallstones

_____ Liver disease (NASH, fatty liver, elevated liver tests, hepatitis, cirrhosis)

_____Lower GI problems (colitis, irritable bowel, constipation, diarrhea, hemorrhoids)

_____Upper GI problems (reflux, hiatal hernia, ulcers, indigestion, Barrett's esophagus)

_____ Breathing problems (asthma, bronchitis, emphysema, chronic cough)

_____Allergies or chronic sinusitis

_____Blood disorders (Anemia, clotting problems, low WBC, thrombophlebitis, bruising)

_____Back problems (pain, sciatica, herniated discs, spinal stenosis, back strain)

_____Migraine, headache, seizures, febrile seizures, head trauma, memory loss, cognition

_____Weight gain, weight loss

_____Muscle weakness, numbness, poor coordination, tremor, pain

_____Depression, anxiety, panic attacks, mania, bipolar, ADD, OCD, psychoses

_____Vision-changes, glaucoma, cataracts, blurred

_____Eating disorders-bulimia, anorexia, binge eating, night eating, overeating

_____Cancer Type:

_____Urinary tract- infections, frequency or pain on urination, kidney stones, blood in urine

_____Menstrual abnormalities-infrequent/heavy periods, fibroids, endometriosis, PCOS, PMS

_____Menopause, incontinence, decrease libido, infertility, cervical dysplasia, abnormal pap

_____Prostate problems, erectile dysfunction, decreased libido, infertility, urinary flow

_____Thyroid problems (hypothyroid, hyperthyroid, goiter, nodules, cold/heat intolerance)

_____Hearing problems (ringing in ears, hearing loss, deaf, hearing aid)

_____Skin conditions (acne, psoriasis, dermatitis, eczema, dry skin, rash, change in moles,)

_____Joint problems such as arthritis, replacements, gout, pain, stiffness

_____Osteoporosis, osteopenia (decreased bone density), fractures

_____Drug or alcohol dependence- current or in recovery?

_____Fatigue, fibromyalgia

_____Memory, concentration issues

_____Other:

Are you currently seeing a mental health professional? Y N
Please provide name and contact:

Have you sought counseling in the past? Y N

Have you had any of the following problems? Y N If so for how long? For more than 2 weeks? Y N

- trouble falling asleep, staying asleep or sleeping too much?
- feeling tired or having little energy?
- trouble concentrating on things such as reading the paper or watching TV?
- being so fidgety or restless that you were moving around a lot more than usual?
- feeling down, depressed or hopeless?
- feeling bad about yourself--or that you are a failure or have let yourself or your family down?
- poor appetite or overeating?
- little interest or pleasure in doing things?
- moving or speaking so slowly that other people could have noticed?
- had thoughts that you would be better off dead or hurting yourself in some way?
- easily annoyed or irritated?
- bothered by any muscle tension, aches or soreness?
- feeling nervous, anxious or on the edge?

Have these problems **made it hard for you to do your work**, take care of things at home or get along with others?

Have you been **worrying a great deal** about a lot of things? If so, do you find that you can't stop worrying?

Have you ever had thoughts of hurting yourself? Y N If so, what are they?

Have you ever attempted suicide?
Have you ever been hospitalized for depression?

List any prescribed **medications** and the **dose** you are **currently** taking and the **date** they were prescribed (please **include** any **over-the-counter medications** like aspirin, tylenol, ibuprofen, cold-allergy, sleep, dietary supplements, herbs, vitamins):

Please list any **drug allergies** that you have and the type of reaction you have:

For women only: Number of pregnancies: _____ Number of live births: _____
Are you still menstruating? Y N If not, when did they stop? _____
If so, are your periods regular (21-35 days)? ___ heavy? __ other: _____Date of last period:_____
Do you perform a monthly self breast exam? Y N Do you have any breast problems? Y N
Nipple discharge? Y N Pain? Y N Fibrocystic change? Y N Have you had a breast biopsy? Y N
Are you sexually active? Y N What form of birth control are you using? _____

Family Health History: Please complete the list below:

	Age	Health / Medical Illnesses	If deceased, age and cause of death
Mother:			
Father:			
Sister/brother(s):			
Aunts/Uncles:			
Grandparents:			

Please indicate immediate family members with any of the following:
diabetes; heart disease (younger than 50y); obesity; cancer; high cholesterol; thyroid disease; endocrine diseases, HTN, kidney stones, depression, anxiety; alcoholism/drug addiction; eating disorders: bulimia/anorexia

Tobacco Use: Do you currently smoke cigarettes? Y N For how many years? ____ How many packs/day?
Have you smoked in the past? Y N For how long? _____ Have you had a chest x-ray? Y N

Alcohol use: Please estimate how much you drink of the following per week
_____ wine (glasses/wk); ____ beer (cans or bottles/wk); _____liquor (oz/wk); _____ mixed drinks(per/wk)
Does your drinking differ during the week compared to the weekend? Y N

Do you use recreational drugs? Y N Have you in the past? Y N

Sleep

Number of hours sleep per night? _____

Do you nap? Y N If so, average duration of a nap? _____

Do you **feel rested** upon awakening? Y N Daytime sleepiness or decreased mental alertness? Y N

Do you have **difficulty falling** asleep? Y N Do you have nighttime awakening? Y N

Do you use sleep aids? Y N What? _____How often?_____

Do you snore? Y N Have you had a sleep study? Y N

Do you **have sleep apnea**? Y N If so, do you use CPAP or Bipap? _____

Do you fall asleep in front of the TV? Y N

Stress/Coping

Do you feel that you have an excessive amount of stress in your life? Y N

Do you have a support network? Y N

What **helps you manage stress**?

Do you meditate or practice a relaxation technique? Y N If yes, what/how often? _____

Do you use food to cope with stress? Y N _____

Do you eat (circle any that apply)

until you are uncomfortable until you are sick large amounts of food when not hungry

without a sense of control (addictive-like)

After overeating, how do you feel?

Are you able to feel a sense of fullness? Y N

Do you experience a sensation of being hungry? Y N

How does being hungry make you feel?

When do you like to eat the most?

when alone with others socially with spouse/family late at night when others are asleep

I eat more when I am feeling (circle any):

anxious stressed guilty in conflict with someone bored lonely angry inadequate embarrassed used out of control happy like celebrating don't care helpless powerless need for a reward

Do you feel preoccupied with food? Y N (circle any that apply)

planning/acquiring food thinking about eating or *not* eating hoarding or hiding food

Do you have a history of switching to another compulsive activity when controlling eating, such as gambling, shopping, alcohol, shoplifting, etc.? Y N

Do you feel that you have a *food* or *eating* addiction? Y N

Weight History

What is your **current** weight? _____Most you have ever weighed and age? _____ Least and age? _____

What do you believe is a **realistic and sustainable** weight for you? _____ Is this your weight loss goal? Y N

What is the most important measure of your weight? scale clothes energy/stamina other:

Does your body weight affect your social or work activities? _____

What **factors are motivating you** to lose weight? _____

What do you see as your biggest challenges or what have you experienced before as an impediment to loss?

_____

What helped you lose/maintain your lowest weight?

What other weight-loss methods/support have you tried and when?

Have you kept a **food or exercise record** before? Y N Was it helpful? Y N

What makes you vulnerable for weight re-gain? _____

Have you used medication to help manage your weight and if so what? _____

Did you have any side-effects of the medication(s)? _____

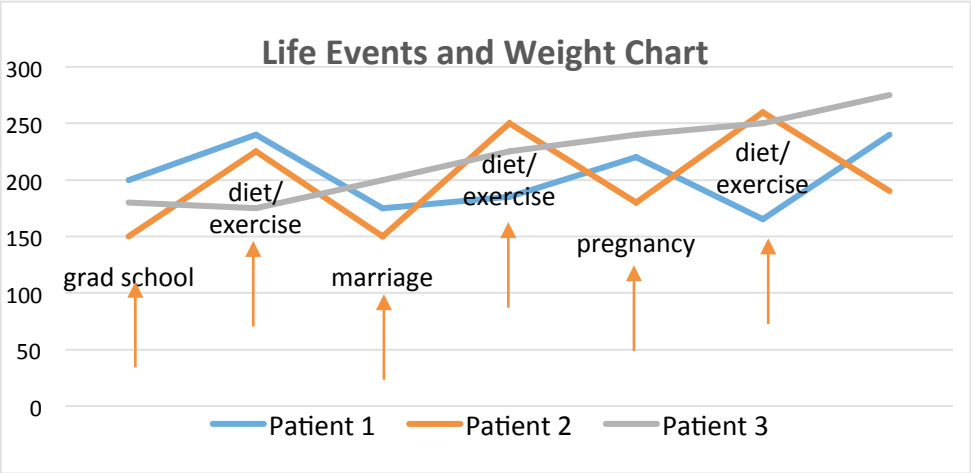
Have you ever? vomited after overeating taken diuretics/laxatives to lose weight

avoided eating 24 hours or more after eating exercised for longer to compensate for overeating

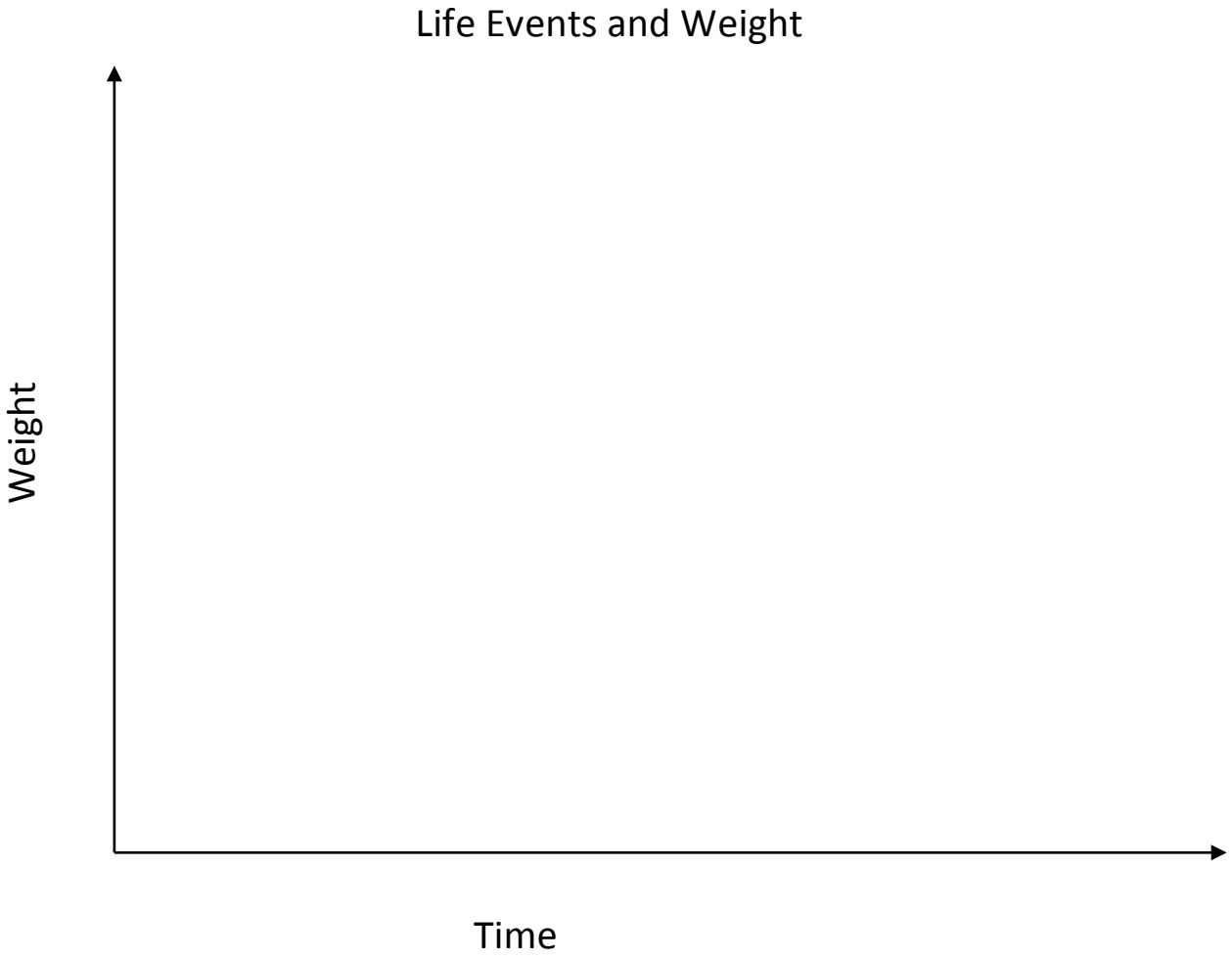
How does your spouse/partner/significant other feel about your weight?

Are they supportive and in what way?

Does he/she struggle with weight?



Each individual has a different pattern of weight loss/gain over a lifetime. It is helpful to identify the factors that may have contributed to weight loss or gain by charting your weight change over time. **At each weight change point, indicate the reason or life event that contributed to the change in weight**. For example, started school, got a promotion, got married, pregnancy, death of a close friend or family member, started a diet, became self-employed, started or stopped exercising, had an injury, retired or stopped working. See example above.



Activity

How active are you? (Check off and describe *what you do* or what you *would be most likely* to participate in)

___very (exercise 4+ days a week): _____

___moderately (exercise 2-3 days a week): _____

___sedentary (currently, not exercising): _____

Does your **lifestyle incorporate activity** (walk/metro/on feet at work?) Y N _____

Do you currently use a device to track your steps? Y N approximate daily average? _____

Do you have any **physical limitations that hinder** your ability to movement? (ie: joint pain, previous surgeries, current injuries) Y N Describe: _____

Have you had treatment (physical therapy/pain management/etc.)?_____

Do you **feel discomfort** when active/exercising? Y N (circle any)

chest pain shortness of breath pain in calves pain sweat other:

How does this discomfort affect your desire to engage in activity?

What would be your **realistic and sustainable goals** for physical activity (initial and long-term)?

How motivated are you to starting/changing your activity? Very 1 2 3 4 5 Not at all

What do you see *in the way* of starting/changing your activity level? _____

Can you think of a way to remove that block? _____

Nutrition/Food Management

If you could change anything about the way you eat, what would it be and how can we help you change it?

How confident do you feel to make changes in your diet? Very 1 2 3 4 5 Not at all

What is the **biggest challenge for you regarding your food management**?

How many fruits do you eat in a day? _____ How many vegetables? _____

Do you have food sensitivities or dietary restrictions?

How comfortable are you with **preparing food/cooking?** Very 1 2 3 4 5 Not at all

Don't know how Not interested Don't have time Would like to learn

Approximately how many times a week do you dine out? _____cook ?_____ buy prepared food? _____

Where do you eat? kitchen dining room in front of TV in car bedroom at desk other:

How often do you skip meals?

Do you have any **habits or triggers** around managing food?

When do you feel most susceptible to overeating?

What type of food?

Please **record an example** of your daily intake. If you don't eat that meal, please put a N/A.

MEAL	**TIME**	**FOODS EATEN**
Breakfast	_____	_____
Snack	_____	_____
Lunch	_____	_____
Snack	_____	_____
Dinner	_____	_____
Snack	_____	_____

To the best of my knowledge the above medical history is true:

Signature _____Date _____

Intake assessment reviewed by: _____Date _____