Physicians WEIGHT LOSS Centers®

Serious Weight Loss Only A Physician Can Deliver™

Client Information Questionnaire

Date: ____________________

To help us serve you better, please complete this questionnaire by checking the appropriate boxes and explaining where applicable.

Personal Information

Name ____________ Phone ____________

Address ____________

City ____________ State ____________ Zip ____________

Email ____________

Occupation ____________

Birth date ____________ Age ____________

Spouse Name ____________ Occupation ____________

Health History

Personal Physician ____________

Physician's Phone # ____________

Date of Last Physical Exam or Visit ____________

Known Allergies ____________

Medication now taking ____________

____

____

Are you now under a physician's care for any acute or chronic medical condition requiring regular treatment? Y N

Describe briefly ____________

Have you ever received treatment for any of the following?

- Y N Cancer
- Y N Liver Disease/Hepatitis
- Y N Kidney Disease
- Y N Gout
- Y N Heart Attack/Heart Surgery
- Y N Gall Bladder Disease
- Y N Gastric or Duodenal Ulcers
- Y N Emphysema
- Y N Diabetes
- Y N Hypoglycemia
- Y N Stroke/TIA's
- Y N HIV/AIDS
- Y N Anorexia or Bulimia
- Y N Lithium Therapy
- Y N Drug or Alcohol Addiction

Are you now pregnant or breast-feeding? Y N

Are you currently being treated for any of the following?

- Y N Diabetes
- Y N Heart Problems/Chest Pains
- Y N Gall Bladder Problems
- Y N Kidney Problems
- Y N Gastric Ulcers
- Y N Cancer
- Y N Skin Rash/Itchy Skin
- Y N Allergies/Sinus Trouble
- Y N Frequent Colds
- Y N Arthritis
- Y N Leg Cramps
- Y N Swollen hands/feet
- Y N Dizziness/Fainting Spells
- Y N Tiredness
- Y N Backache
- Y N Asthma/Emphysema
- Y N Tuberculosis
- Y N Headaches
- Y N Poor Digestion
- Y N Bloating
- Y N Diverticulitis/Colitis/Enteritis
- Y N Stomach Burning/Indigestion
- Y N Irregular Bowels
- Y N Difficulty Sleeping
- Y N Severe Nervousness

If you answered yes to any of the above, describe briefly: ____________

____

____

List surgeries within the last 5 yrs:

____

____

Have you had intestinal or gastric bypass surgery? Y N

Personal History

1. How did you hear about Physicians Weight Loss Centers?
   Newspaper Ad ☐ Phone Solicitation ☐ Friend ☐ Postcard ☐ Flyer ☐ Other: ____________
2. What was your weight when you felt your best? ____________ Your age then ________
3. Current Weight ________ Dress/Slack Size ________ Desired Weight ________ Desired Dress/Slack Size ________
4. What was your heaviest weight? ________ Your age then ________ When did you start to gain weight? ________

   How long did it take you to gain the excess weight? ____________

5. What, if anything, have you done to previously lose weight? Other:____________________

☐ Exercise ☐ Nutrisystem ☐ Fasting ☐ Weight Watchers ☐ Jenny Craig ☐ Atkins ☐ Pills

6. How successful were you? ____________________

7. Is your spouse or family members overweight? ☐ Yes ☐ No

8. Will your family help you diet? Y N If not, who will you turn to for support?____________________

9. How important do you think it is to have a diet partner? ☐ Very ☐ Not Very ☐ No Opinion

10. Does your schedule allow you a few minutes each week to visit our Nurses and Staff counselors? Y N

11. Why is it important for you to lose weight fast? ☐ Appearance ☐ Doctor's Suggestion ☐ Tight Clothes

☐ Upcoming Event ☐ General Health ☐ Self-Esteem ☐ Other

If other, please Explain: ____________________

12. Do you take time to plan and cook your meals? ☐ Yes ☐ No Or do you prefer fast foods? ☐ Yes ☐ No

13. Who prepares the meals at home?____________________

14. What describes you best? I eat too much: when nervous ☐ for pleasure ☐ when upset ☐.

15. A typical day's food intake for me includes approximately __________calories. List what you normally have for:

Breakfast ________	**Mid Afternoon** ________	**Snacks** ________
Mid Morning ________	**Dinner** ________	**Beverages** ________
Lunch ________	**Evening** ________	**Desserts** ________

16. What do you do for fun, hobbies and recreation? ____________________

17. Which best describes your activity level for the last 6 months? ☐ Sedentary (little or no exercise)

☐ Lightly Active (Exercise 1-3 days per week) ☐ Moderately Active (Exercise 3-5 days per week)
☐ Very Active (Exercise 6-7 days/week ☐ Extra Active (Exercise 6-7 days/week and physical job)

Any other comments / information?____________________

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Signature: ____________________