INTAKE FORM

University Hospitals
Brunner Sanden Deitrick
Wellness Center

Fitness

Weight Loss Program

Name: ______________________ Age: __________ Date of Birth: __________
Address: ______________________ City: __________ Zip Code: __________
Phone (Day): ______________________ Cell or Evening: ______________________
Occupation: ______________________
Any physical activity at work?: ______________________
E-mail Address: ______________________
Personal Physician: ______________________ Phone: ______________________

Adult Weight History

Height: __________ Weight: __________ BMI (if known): __________
Minimum Weight: __________ Age: __________ Maximum Weight: __________ Age: __________
Age at onset of weight problems? __________
Previous weight-loss methods? ______________________
What is your reason for wanting to lose weight at this time?

____

____

Other than weight, what goals do you have for yourself in regards to your health and lifestyle?

____

____

____

Social Support System

Who do you live with? ______________________

Are they supportive of your decision to lose weight and how do you think they will be supportive?

____

____

Social History

Tobacco: ☐ Yes ☐ No How much per day? ______________________

Alcohol: ☐ Yes ☐ No How much per day/week/month/year? ______________________

Caffeine consumption: ☐ Yes ☐ No What? __________ How often? __________

Recreational drugs: ☐ Yes ☐ No What? __________ How often? __________

Routinely exercise: ☐ Yes ☐ No What? __________ How often? __________

Do you walk a mile or more daily? ☐ Yes ☐ No

(See page 2)

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Medical History

Do you have any of the following? Please circle all that apply and provide additional information for items circled under Group A in the lines below.

GROUP A (requires physician monitoring)	**GROUP B**	
• Diabetes	• Anemia/Other Blood Disease	• Sleep Apnea on CPAP
• Heart Failure or Angina	• Arthritis (bone/joint disease)	• Low Thyroid
• Taking Coumadin	• Reflux	• Food Allergies
• Kidney Failure	• Constipation or Diarrhea	• Cancer
• Liver Failure or Cirrhosis	• Gout	• Other Current Medical Conditions
• High Blood Pressure	• Seizures/Convulsions	
• Gallstones		

Group A Details:

____

____

Psychiatric (please circle and continue current treatment):

- Depression
- Bulimia
- Substance/Alcohol Addiction
- Anxiety Attacks
- Anorexia Nervosa
- Ongoing Counseling

Recent hospitalization and/or surgery (include dates):

____

____

Current Medications

List all current medications you take:

____

____

Diuretics? ____________________ Insulin? ____________________