Health History Questionnaire

Name: _____

Current Weight: _____ Goal Weight: _____

Highest Weight: _____ Lowest Weight: _____

Goals

Write down 3 (or more!) goals that you want to accomplish in the next 12 weeks. Try to be as specific as possible. These goals are for you only; no one else has to know about them unless you want them to. Be reasonable, but set goals that will help motivate you to push yourself.

Example:

1. I will keep a detailed food journal to help me track my eating habits.
2. I want to be able to do 25 pushups without stopping.
3. I want to fit into jeans at least 1 size smaller than what I wear now.

Goal #1. _____

_____

Goal #2._____

_____

Goal #3._____

_____

Reasons

Write down at least 3 reasons to change. These are your motivators, so they should be specific and personal to you. Think of these every day, and every time you feel discouraged or down. If you think of more as you go along, write them down so you don't forget.

Example:

1. To have more energy to play with my kids.
2. To teach my family the value of a healthy lifestyle.
3. To feel confident in my own body.

Reason #1. _____

_____

Reason #2._____

_____

Reason #3. _____

_____

Health History Questionnaire

What are your expectations do for this consultation? _____

_____

Have you ever been diagnosed with an eating disorder? YES NO
If yes, please explain: _____

Are you currently taking any Vitamin / Mineral supplements? YES NO
If yes, please list: _____

Are there any foods that you avoid? YES NO
If yes, please list: _____

Are you Vegetarian? YES NO Vegan? YES NO

How do you rate the overall nutritional content of your current diet?

Excellent Very Good Satisfactory Poor Unsure

How do you rate your ability to plan meals each day that are heart healthy, cancer preventative & have a mix of calories and nutrients to meet your health and fitness goals?

Excellent Very Good Satisfactory Poor Unsure

How often do you include fish in your meal plan?

2 or more meals/week 1 meal/week 1-3 meals/month Never

How often do you eat baked goods or sweets (pies, cakes, cookies, sweet rolls, muffins, doughnuts, dessert bars, ice cream, frozen yogurt or chocolate)?

5 or more times a week 2-4 times a week 1-2 times a week Never

Average number of home-prepared meals each week:

0 1 2 3 4 5 6 7 8 9 10 11 12+

Average number of restaurant meals (sit-down, fast food, take out) each week:

0 1 2 3 4 5 6 7 8 9 10 11 12+

My restaurant meals tend to be (circle all that apply)

Breakfast Lunch Dinner

When eating out, I tend to “clean my plate”:

Always Most of the time About 50% of time Occasionally Never

Health History Questionnaire

What does your current daily nutrition intake look like? Include times.

BREAKFAST: _____

SNACK: _____

LUNCH: _____

SNACK: _____

DINNER: _____

SNACK: _____

Is your daily nutrition during the work week different on the weekends? YES NO

If yes, please explain: _____

_____

On average, how many days per week do you consume alcoholic beverages?

0 1 2 3 4 5 6 7

On average, how many alcoholic drinks do you consume on days you drink?

1 2 3 4 5 6 7 8 9 10 11 12+

What types of alcohol do you consume?

Beer Wine Liquor Spritzer Other _____

On average, how many caffeinated beverages do you consume per day?

0 1 2 3 4 5 6 7 8 9 10 11 12+

What types of caffeinated beverages do you consume? _____

Do you use tobacco products? YES NO

If yes, select type of tobacco: Cigarettes Chewing Tobacco E-Cigarettes Other: _____

If yes, how many times per day do you use said substance?

1 2 3 4 5 6 7 8 9 10 11 12+

Do you feel stress throughout the day? YES NO If yes, how stressed are you typically?

Not At All Mild Moderate Severe Very Severe Extreme

Health History Questionnaire

In what ways do you manage your stress? _____

_____

Have you seen a counselor / therapist in the past, or are you currently working with a medical professional?

_____

What have you tried in the past to achieve your nutrition and fitness goals? Include any diet or exercise program, supplement use, books, etc.:

_____

_____

Are you currently on an exercise program? YES NO

If so, please elaborate below:

Type of Exercise	Workouts per week	Duration of workout	Perceived exertion level (1-10)
Weight Training	_____	_____	_____
Aerobic Training	_____	_____	_____
Activities (golf, tennis, volleyball, etc.) _____		_____	_____

Are you currently working with a personal trainer or coach? YES NO

If yes, who and how often? _____

Have you had any surgeries that have resulted in loss of movement or a movement restriction? YES NO

If so, please elaborate: _____

Do you currently have pain associated with motion?
YES NO

If yes, explain each movement and elaborate on chart:

_____

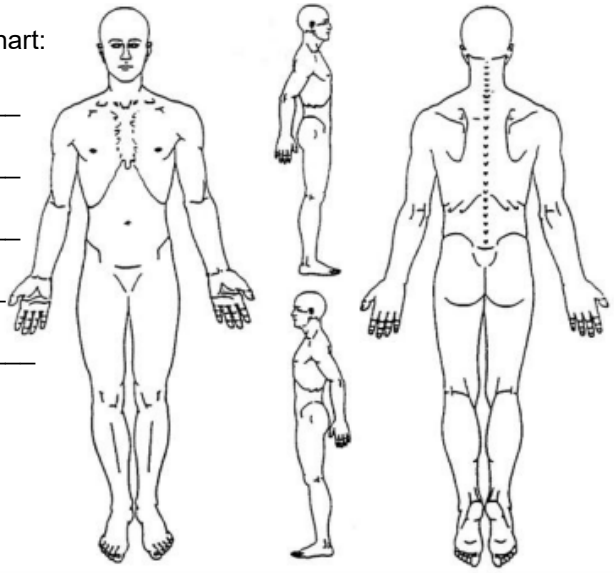
_____

_____

_____

_____

Please indicate on the body chart where your **symptoms** are located.
→→→ Burning, sharp, shooting XXX Numbness/Tingling
000 Dull/aching pain //// Throbbing



EMPOWER 2 WELLNESS

PATIENT INFORMATION SHEET

Last Name	First Name	MI

Date of Birth	Age	Contact Number	Preferred Reminder ☐ Phone ☐ Email

Email Address

Address	City	State	Zip Code

Social Security Number	Driver License #

Marital Status Divorced Married Single Widow/Widower	Sex Male Female

Employer	Occupation	Work Phone

Employer Address	City	State	Zip Code

IF INSURANCE IS CARRIED BY SOMEONE OTHER THAN THE PATIENT, PLEASE COMPLETE THIS BOX:

Last Name	First Name	MI

Date of Birth	Age	Home Phone

Address	City	State	Zip Code

Social Security Number	Driver License #	Relationship to patient

Employer	Employer Address

Work Phone	Occupation

EMERGENCY CONTACT INFORMATION

Name	Relationship	Phone number

PRIMARY INSURANCE INFORMATION

Insurance Company Name	Insurance Phone Number

Policy/Certification Number	Group/Account Number

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company Name	Insurance Phone Number

Policy/Certification Number	Group/Account Number

PRIMARY CARE PHYSICIAN INFORMATION

Primary Care Physician Name	Primary Care Physician Phone Number

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

- ☐ Internet: Facebook/Google Search: String_____
- ☐ Friend/colleague: Name: _____
- ☐ Physician/Other/Medical Provider: Name: _____
- ☐ Other:

I certify that the above information is true and correct to the best of my knowledge. As the responsible party, I agree that all charges that are not directly paid by my insurance will be my responsibility.

Responsible Party Signature: _____ Date: _____

EMPOWER 2 WELLNESS

MEDICAL HISTORY & WEIGHT LOSS QUESTIONNAIRE

NAME: _____ DATE OF BIRTH: _____ AGE: _____

ALLERGIES TO MEDICATIONS: □ NONE □ YES: _____

MEDICATIONS: ☐NONE

Name of Medication	Dosage & Frequency

OFFICE USE:

PREVIOUS SURGERIES: ☐ NONE

Procedure	Year	Hospital	Indication

Current Height:	Current Weight:	Goal Weight
Lowest adult weight:	Highest adult weight:	

Diet Programs & OTC Supplements	Previous (Circle one)		Current (Circle one)		Dates tried (If applicable)	Pounds lost (If applicable)
Calorie restriction	Y	N	Y	N		
Food journaling/food diary	Y	N	Y	N		
Exercise	Y	N	Y	N		
Weight Watchers	Y	N	Y	N		
Jenny Craig	Y	N	Y	N		
Nutri-system	Y	N	Y	N		
Medifast	Y	N	Y	N		
Optifast	Y	N	Y	N		
South Beach	Y	N	Y	N		
Atkins	Y	N	Y	N		
Slim-Fast	Y	N	Y	N		
hCG Diet	Y	N	Y	N		
Hydroxycut	Y	N	Y	N		
Hypnosis	Y	N	Y	N		
Behavior modification	Y	N	Y	N		
Acupuncture	Y	N	Y	N		

Weight Loss Medication	Previous		Current		Dates tried	Pounds lost
Amphetamines	Y	N	Y	N		
Phentermine (Adipex, Fastin, Pondimin)	Y	N	Y	N		
Sibutramine (Meridia)	Y	N	Y	N		
Orlistat (Xenical, Alli)	Y	N	Y	N		
Phen-Fen	Y	N	Y	N		
Redux (Dexfenfluramine)	Y	N	Y	N		
Other (specify):	Y	N	Y	N		

EMPOWER 2 WELLNESS

MEDICAL HISTORY & WEIGHT LOSS QUESTIONNAIRE

FAMILY HISTORY: INDICATE FAMILY MEMBERS HAVING ANY OF THE FOLLOWING ILLNESS

	MOTHER	FATHER	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	SIBLINGS	CHILDREN
OBESITY								
DIABETES								
HIGH BLOOD PRESSURE								
HEART DISEASE								
CANCER								
SEIZURES								
BREATHING PROBLEMS								
KIDNEY DISEASE								
ARTHRITIS								
EARLY DEATH & CAUSE								
OTHER								

SOCIAL HISTORY:

Smoking: □ No □ Yes (# packs/day: _____; years of tobacco: _____)
Alcohol: □ No □ Yes (_____ drinks/week)
Caffeine: □ No □ Yes (tea/coffee: _____ cups/day; soda: _____ cans/day) Exercise:
□ No □ Yes (_____ times/week)

Have you ever been treated for depression? Yes No
Are you currently in treatment? Yes No
If yes, please indicate the name of your physician or therapist:
_____
Have you ever been hospitalized for mental illness? Yes No

SYSTEMS REVIEW: please circle all that apply

Constitutional:
Fatigue
Tiredness
Recent Weight Loss
Fever
Night Sweats
Abnormal Bleeding

Head and Neck:
Blurred vision
Double vision
Loss of vision
Loss of hearing
Sinus Congestion
Runny nose / Sneezing
Vertigo
Loss of smell
Sinus infection
Sore throat
Pain/Difficulty Swallowing
Hoarseness
Lump in neck

Respiratory:
Shortness of breath
Asthma
Wheezing
Cough
Bloody sputum
Emphysema
Pneumonia
Bronchitis
Difficulty sleeping flat
Waking at night short of breath

Gastrointestinal:
Jaundice
Hepatitis / Cirrhosis
Heartburn
Vomiting / Nausea
Abdominal Pain
Irritable Bowel / Pain
Hemorrhoids / Colitis
Diarrhea / Constipation
Bloody Stool / Change in Size

Men:
Discharge from penis
Loss of erection

Women:
Vaginal Discharge
Abnormal vaginal bleeding
Irregular periods
Hysterectomy
Pap exam within last year

Musculoskeletal:
Pain in joints
Muscular aches
Swelling of joints
Arthritis
Pain in Hips / Knees
Pain in Ankles / Feet
Low Back Pain / Sciatica
Herniated Disk
Numbness in Feet or Legs
Abnormal Lumps or Masses

Skin/Breast:
Skin Cancer
Abnormal Moles
Burns
Rash
Breast mass
Nipple discharge
Mammogram with
in last year
MRSA

Neurological:
Convulsions
Fainting
Vertigo
Light headedness
Falling
Muscle weakness
Numbness
Tremors
Stroke
Loss of Consciousness

EMPOWER 2 WELLNESS

MEDICAL HISTORY & WEIGHT LOSS QUESTIONNAIRE

Cardiovascular:	**Genitourinary:**	**Endocrine:**	**Psychological:**
Chest pain	Blood in urine	Hyperthyroid	Depression
Pain in arm/neck	Frequent urination	Hypothyroid	Nervousness
Heart attack	Leakage of urination	Goiter	Anxiety
Palpitations	Pain with urine	Previous radiation	Suicidal thoughts
Heart pounding	Trouble starting urine	Diabetes	Suicide attempts
Stroke	Bladder infection	Adrenal gland tumor	Schizophrenia
Heart murmur	Kidney stones	Previous steroid use	Anorexia
Pain in legs		Swollen glands	Bulimia
Cold feet			Binge eating
Loss of pulses			Counseling
Low blood pressure			Bipolar disorder
High blood pressure			Hospitalization for emotional problem
Abnormal heart beat			

WEIGHT RELATED MEDICAL HISTORY (do you have or have you had any of the following illness or symptoms?)

Heart disease	Yes	No	Year of diagnosis _____
Angina	Yes	No	Year of diagnosis _____
MI (Heart attack)	Yes	No	Year of diagnosis _____
Coronary bypass surgery	Yes	No	Year of surgery: _____
Palpitations (abnormal heart beat)	Yes	No	Year of diagnosis _____
Congestive heart failure	Yes	No	Year of diagnosis _____
High blood pressure	Yes	No	Year of diagnosis _____
Elevated cholesterol	Yes	No	Year of diagnosis _____
Elevated triglycerides	Yes	No	Year of diagnosis _____
Weight loss surgery	Yes	No	Year of surgery: _____
Asthma	Yes	No	Year of diagnosis _____
Reflux	Yes	No	Year of diagnosis _____
Heartburn	Yes	No	Year of diagnosis _____
Esophagitis	Yes	No	Year of diagnosis _____
Hiatal Hernia	Yes	No	Year of diagnosis _____
PCOS (polycystic ovarian syndrome)	Yes	No	Year of diagnosis: _____
Thyroid disease	Yes	No	Year of diagnosis:
Shortness of breath:	Yes	No	
Sleep Apnea	Yes	No	Year of diagnosis _____
Do you use CPAP/BiPAP	Yes	No	
Snoring	Yes	No	
Awakening at night	Yes	No	
Daytime drowsiness	Yes	No	
Observed apnea spells	Yes	No	
Morning headaches	Yes	No	
Venous Stasis	Yes	No	
Leg or ankle edema	Yes	No	
Leg ulceration	Yes	No	
Pain of arthritis	Yes	No	
In ankles	Yes	No	
In knees	Yes	No	
In hips	Yes	No	
Limits ability to walk	Yes	No	
Limits ability to exercise	Yes	No	

Low back pain/Sciatica	Yes	No	
Limits ability to walk	Yes	No	
Limits ability to exercise	Yes	No	
Diabetes	Yes	No	Year of diagnosis _____
Diet controlled	Yes	No	
Oral medications	Yes	No	
Insulin	Yes	No	
Urinary Incontinence	Yes	No	
Leaking urine with cough	Yes	No	
Leaking urine with sneezing	Yes	No	
Leaking urine with straining	Yes	No	
Migraine	Yes	No	
Frequency _____			
Deep Venous Thrombosis	Yes	No	Year of diagnosis _____
Pulmonary embolism	Yes	No	
Abdominal wall hernia	Yes	No	
Incisional	Yes	No	
Umbilical	Yes	No	
Number of hernia repairs _____			
Have you ever had:			
Blood transfusion	Yes	No	
Hepatitis	Yes	No	
Exposed to HIV/AIDS	Yes	No	
Abused intravenous drugs	Yes	No	

PAST MEDICAL HISTORY

Please list all other medical conditions, illness or important information not previously mentioned:

_____

_____

_____

Patient signature: _____ Date: _____

The above is true, correct and complete to the best of my belief

Medical information has been reviewed by:

Physician signature: _____Date: _____

HIPAA FORM

In our efforts to comply with the health information privacy act, HIPPA, we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends and co-workers.

Please circle your choice responses to the following questions:

May we leave messages concerning your appointments/treatment with a co-worker, receptionist or secretary that regularly answers your phone calls?	Yes	No
May we leave messages on a voice mail at work?	Yes	No
May we leave messages on an answering machine at home?	Yes	No
May we leave information with a spouse or significant other?	Yes	No
Is there anyone that is not listed above that we can give information to? If so, please specify? _____	Yes	No
For any children above 18 that are still living at home, may we discuss your appointments/treatments with your parent(s) or Guardian?	Yes	No
I would like to receive regular e-mail updates and/or newsletters:	Yes	No

_____
E-mail address

You must inform us, in writing, of any changes in your directives. This record takes effect May 2017 and will be kept in your file with your acknowledgment of receipt of our Notice of Privacy Practices.

Signature:_____ Date:_____

Print Name:_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third-party payers, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or the payment thereof.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information, to provide you with this Notice of Privacy Practices, and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak with the office Manager or Privacy Officer to obtain additional information regarding any questions you may have concerning this notice or to receive a printed copy of this notice. This Notice of Privacy Practices is effective as of May 2017.

Patient name: _____

Patient/Legal Guardian Signature: _____

Date: _____