Individual Intake Questionnaire

** indicates a required field*

*** Please provide your name and date of birth.**

*** What is your current address?**

*** Please provide your phone number and email.**

*** What are your height and weight?**

Medical History

*** Are you under the care of a qualified healthcare professional? Please list whom.**

*** Please list any medical conditions a medical provider has diagnosed you with in the past (such as high blood pressure, diabetes, arthritis, etc...)**

*** Do you have any history or family history of medullary thyroid cancer, multiple endocrine neoplasia type 2, or pancreatitis?**

*** What medications, supplements, and over-the-counter items do you take regularly or are currently prescribed?**

*** Do you have any known allergies to food or medications?**

*** Any past surgeries and hospitalizations?**

*** Please describe your family history in terms of heart disease, diabetes, obesity, high cholesterol, high blood pressure, cancer, etc.**

Personal History

*** What are your main interests and hobbies?**

*** What is your line of work or study?**

*** How many hours of sleep do you typically get, and do you feel well-rested upon awakening?**

*** How is your energy? Does your energy level affect your daily activities?**

*** How would you describe your stress level?**

*** What are your sources of stress, and how do you manage them?**

*** Do you have people close to you who support you?**

Diet and lifestyle

*** What do you find yourself typically eating?**

*** Do you eat regular meals throughout the day?**

*** Do you exercise regularly? Please detail.**

*** What kind of other movement or activities do you enjoy?**

*** Do you smoke tobacco or use any recreational drugs? If so, what and how often?**

*** Do you currently drink alcohol? If so, describe the type, amount, and how often (daily, weekly, monthly, etc.).**

- ◯ Yes
- ◯ No

*** What diet and exercise programs, protocols, plans or approaches have you tried in the past?**

Weight History

*** How did your weight gain start? Describe any circumstances:**

*** What do you think is the cause of your weight problem?**

*** Please list the factors you feel have contributed to your current weight (check all that apply):**

- [ ] Slow metabolism
- [ ] Family history of obesity
- [ ] Comfort food dependency
- [ ] Lack of exercise
- [ ] Binge eating
- [ ] Late night snacking
- [ ] History of trauma, grief, or loss
- [ ] Medication related weight gain
- [ ] Other

*** How motivated are you to lose weight?**

*** Please click any of the following conditions that are applicable**

- [ ] Fatigue
- [ ] Unexplained weight loss or gain
- [ ] Change in appetite
- [ ] Depressive symptoms
- [ ] Anxiety
- [ ] Mood swings
- [ ] Nervousness
- [ ] Addictive dependency
- [ ] Disordered eating pattern/tendency
- [ ] Lack of mental focus
- [ ] Thyroid problems
- [ ] Diabetes
- [ ] Blood Sugar irregularities
- [ ] Excessive thirst or hunger
- [ ] Feeling excessively hot or cold
- [ ] Shortness of breath
- [ ] Constipation
- [ ] Diarrhea
- [ ] Nausea
- [ ] Diabetese
- [ ] Arthritis
- [ ] Thyroid issues
- [ ] Cancer
- [ ] Other

*** What else would you like us to know?**

*** How did you hear about us?**