Patient Registration

Patient Information	**Person Responsible for Bill** (Guarantor)
Last Name:	Name:
First Name:	Address:
Middle Name:	
Address:	Relationship to patient:
City: State:	Date of Birth:
Zip:	Social Security No.:
Home Phone:	Phone:
Mobile Phone:	
Sex:	**Emergency Contact Information**
Date of Birth:	Name:
Social Security No:	Relationship:
Ethnicity:	Phone:
Email:	Mobile Phone:
Pharmacy: Location:	
Lab: Location:	

Primary Insurance

Name of Insurance Plan:	Patient's relationship to policy holder:
Policy Holder (If other than patient)	ID/Certification No.:
Last Name:	Policy / Group No.:
First Name:	
Middle Name:	
Address:	
City:	
State: Zip:	
Date of Birth: Sex: M F	
Employer Name:	

Secondary Insurance

Name of Insurance Plan:	Patient's relationship to policy holder:
Policy Holder (If other than patient)	ID/Certification No.:
Last Name:	Policy / Group No.:
First Name:	
Middle Name:	
Address:	
City: State: Zip:	
Date of Birth: Sex: M F	
Employer Name:	

The above information is true to the best of my knowledge:

Patient / Guardian Signature: Date:

Name:_____ Date of Birth:_____

Allergies *(drugs & food)*

Drug / food	Type of Reaction

Medications

Pharmacy Name:_____ ***Phone:***_____

Name of Medication	Strength (dose)	How often	Purpose

Vaccine

Pneumococcal Vaccine	_____Yes	_____No	(If Yes Date:	Provided by:)
Flu Vaccine	_____Yes	_____No	(If Yes Date:	Provided by:)

Family History

Family member	Obesity	Diabetes	High Blood Pressure	Sleep Apnea	High Cholesterol	Any Addictions	Cancer	Other
Grandmother								
Grandfather								
Grandmother								
Grandfather								
Mother								
Father								
Brother								
Sister								
Son								
Daughter								
Grandson								
Granddaughter								

Name:_____ Date of Birth:_____

General Information

Primary Care Provider: _____Phone#_____
How long has he/she been your doctor: _____
How long at current weight:_____
How Long have you been overweight:_____(years)
At what age did you first start dieting: _____(age)
What was your greatest single weight loss:_____(pounds)
How did you loss this weight (be specific):_____
How long did you sustain that weight loss: _____
Education □↓8th Grade □ 12th Grade □ 2yr College □ 4yr □ Post Grad
Occupation: _____ Employer: _____
Marital Status: □single □married □separated □divorced □widowed?
Live alone or with others: _____
Able to care for self: _____ Yes, _____ No
How many children do you have? ___ daughter(s) ___ son(s)
How many siblings do you have? ___ brother(s) ___ sister(s)
Smoking History
____ never smoked ____ former smoker ___ occasional smoker
____ every day smoker ____ how many packs/day ____ since what age
____ chewing tobacco ___None __1/day __2-4/day __5+/day ____yrs of use
Illicit drug use _____yes _____no _____yrs of use
Alcohol use ____none ____occasional ____moderate ___heavy ____yrs of use
Parents' marital status:___Married, ___Separated, ___Divorced, ___Widowed
Did you have any history of childhood abuse? ___ yes ___ no
General stress level _____Low, _____Medium, _____High
Have you had any legal issues (ie. arrests, bankruptsy, lawsuits)? ___ yes ___ no

Previous Surgeries

Surgery	***Date***	***Reason***
Previous weight loss surgery		
Last colonoscopy (male/female)		
Last prostate (male)		

GYN: Last menstrual cycle:_____ Last PAP:_____
Last Mamo:_____

Past Medical History

Name: _____ Date of Birth: _____

Do you now have or have you had in the past? Please circle answer:

Do you have any beliefs that prohibit the use of blood or blood products?	Yes	No		Anxiety Disorder	Yes	No
				Bi-Polar Disease	Yes	No
				Depression	Yes	No
				Self-harm/Self cutting	Yes	No
Asthma	Yes	No		Suicide attempts	Yes	No
Sleep Apnea	Yes	No		Schizophrenia	Yes	No
Use of C-Pap/Bi-Pap	Yes	No		Alcohol use disorder	Yes	No
COPD / Emphysema	Yes	No		Substance use disorder	Yes	No
Blood clots	Yes	No		Eating disorder	Yes	No
Arrhythmia / A-Fib	Yes	No		Learning disorder	Yes	No
Coronary artery disease	Yes	No		Kidney Disease	Yes	No
Hypertension (High Blood Pressure)	Yes	No		Gout	Yes	No
Myocardial Infarction (Heart Attack)	Yes	No		Liver Disease	Yes	No
Stroke	Yes	No		Bleeding Abnormality	Yes	No
High Cholesterol	Yes	No		Cancer Type _____	Yes	No
Hypothyroid	Yes	No		Connective tissue disease: Sarcoid/Lupus	Yes	No
Diabetes Mellitus __Insulin __non-insulin	Yes	No		HIV	Yes	No
Gallstones	Yes	No		Hepatitis A, B or C	Yes	No
GERD (Gastric Reflux /Heartburn)				Other:		
Arthritis	Yes	No		Other:		

Mobility Assessment

Instructions: please circle the level of difficulty you have for each activity today.	Able to do **without** any difficulty	Able to do with **little** difficulty	Able to do with **moderate** difficulty	Able to do with **much** difficulty	**Unable** to do
Laying flat	1	2	3	4	5
Rolling over	1	2	3	4	5
Moving-lying to sitting	1	2	3	4	5
Sitting	1	2	3	4	5
Squatting	1	2	3	4	5
Bending / stooping	1	2	3	4	5
Balancing	1	2	3	4	5
Kneeling	1	2	3	4	5
Standing	1	2	3	4	5
Walking – short distance	1	2	3	4	5
Walking – long distance	1	2	3	4	5
Walking – outdoors	1	2	3	4	5
Climbing stairs	1	2	3	4	5
Hopping	1	2	3	4	5
Jumping	1	2	3	4	5
Running	1	2	3	4	5
Pushing	1	2	3	4	5
Pulling	1	2	3	4	5
Reaching	1	2	3	4	5
Grasping	1	2	3	4	5
Lifting	1	2	3	4	5
Carrying	1	2	3	4	5
Total					

Name: _____ Date of Birth: _____

Nutrition History

Goal Weight:_____lbs

Highest Weight/age at that weight:_____ lbs / _____age

Lowest Weight/ age at that weight:_____ lbs / _____age

Vitamins: _____ Herbals: _____

Food Allergies: _____

Food Intolerances: _____

Do you eat 3 meals a day? _____

Breakfast – types of foods: _____

Lunch – types of foods: _____

Dinner – types of foods: _____

Snacks – types of foods: _____

Time of day snacking occurs: _____

Food preferences: _____

Caffeine intake: _____ None, _____Occasional, _____Moderate, _____Heavy

Beverage (s) of choice for the day: _____

Amount consumed: _____ounces

Do you have beverages with your meals? _____Yes _____ No

Eating pace: _____Slow, _____ Medium, _____Fast

Portion Size: _____Small, _____Medium, _____Large

Who does the food shopping / preparation? _____

How often do you eat out? _____

Are finances a concern when purchasing food? _____

Motivation for eating (examples: stress boredom, depression etc.)_____

Type of physical activity currently: _____

Frequency /duration of activity: _____

Please list weight loss attempts (diets, exercise, supplements, etc.)

_____

_____

_____

_____