Why Weight, LLC
10268 W. Centennial Rd Ste 204
Littleton, CO 80127

Date: _____

HEALTH QUESTIONNAIRE

Name: _____ Phone (H): _____ (W): _____ (C): _____

Address: _____ City: _____ State: _____ Zip Code: _____

Birthdate: _____ Age: _____ Sex: _____ Marital Status (S,M, W, D): _____ Referred by: _____

Employer and Position: _____ Hours: _____

Spouse/Partner's Occupation and Position: _____

Height: _____ Present weight: _____ Wt at age 18: _____ Desired Wt: _____ Highest wt (non-pregnant) & date: _____

Yes	No		Have you ever had:	Highest BMI _____ & Adjusted BMI _____
		1.	Rheumatic fever, heart disease, high blood pressure, cancer, diabetes, gout, tuberculosis, kidney problems, blood clots, or other serious diseases?	Briefly explain each yes answer below & indicate the number of the question for each response.
		2.	A family history of diabetes, heart trouble, high blood pressure or weight problems?	
		3.	Surgery or serious injury?	
		4.	Problems with your stomach or bowels, such as persistent indigestion, constipation, diarrhea, ulcers or gallbladder trouble?	
		5.	Problems with your kidneys or bladder, such as trouble urinating, frequent urination or burning?	
		6.	Menstrual problems such as cramps, irregularity, spotting, hot flashes, depression or indications of change of life? Date of last Pap (cancer) smear?	
		7.	Problems with heart or lungs, such as shortness of breath, chronic cough, chest pain, rapid or irregular heart beat?	
		8.	Problems sleeping such as getting to sleep or staying asleep?	
		9.	Have you had a problem sleeping that required treatment with prescribed or over the counter sleep aids? Please list.	
		10.	Problems with excessive snoring, sleep apnea or restless legs? Please list any treatment.	
		11.	Problems with swelling of the hands or feet?	
		12.	Arthritis, joint or back problems?	
		13.	Are you taking medication at this time? (Including birth control pills) Please list.	
		14.	Are you allergic to any medications? Please list allergic symptoms.	
		15.	Have you been treated for nerves, depression, psychiatric problems, or attempted suicide? Please explain. When? _____	
		16.	Have you ever had an eating disorder, such as anorexia or bulimia? Please explain.	
		17.	Have you taken weight medications or been treated by a doctor previously for your weight? Explain when and your results.	
		18.	Date of last complete physical _____ Name of PCP _____	
		19.	Number of years overweight _____ PCP Phone _____	
		20.	Weight 6 months ago _____ 1 year ago _____	
		21.	State amount used each day: alcohol/beer _____ Coffee/tea _____ recreational drugs _____ cigarettes _____ Sugar drinks, soda, energy drinks _____	
		22.	Do you exercise? If yes: minutes/day _____Days /wk _____ Type of exercise:	

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Have you been involved in physical activity programs to help with weight loss? YES NO

Which ones or in what way? _____

What questions do you have for our Why Weight Team?

Please write out 3 days of food intake (including beverages etc.)

Breakfast:_____
Mid-morning: _____
Lunch: _____
Mid-afternoon: _____
Dinner: _____
Evening snack: _____

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Mid-morning: _____
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Breakfast:_____
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Patient Signature: _____

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WEIGHT HISTORY QUESTIONNAIRE

Name: _____

1.	**Is it your own decision to lose weight, or someone else's? Please explain.**
2.	**What are your goals about weight management and control?**
3.	**What is the hardest part about managing your weight?**
4.	**What do you believe will be of most help to assist you in losing weight?**
5.	**Are you ready for lifestyle changes to be a part of your program? If yes, please list.**
6.	**Who is your primary support system? How will they provide you with support during your journey?**
7.	**Are there events in your life right now that might make losing weight especially difficult? Please explain.**

As best as you can recall, what was your weight at each of the following time points (if they apply).

Grade school _____ High School _____College _____ Ages 20-29 _____ 30-39 _____ 40-49 _____ 50-59 _____

What has been your lowest weight as an adult? _____ At what age did you start trying to lose weight? _____

Please check all previous programs you have tried in order to lose weight. Include dates and length of participation.

Programs	**Date**	**Weight (lost or gained)**	**Length of Participation**
● TOPS	_____	_____	_____
● Weight Watchers	_____	_____	_____
● Overeaters Anonymous	_____	_____	_____
● Liquid Diets (i.e. Optifast)	_____	_____	_____
● RX Diet pills	_____	_____	_____
● NutriSystem/Jenny Craig	_____	_____	_____
● OTC diet pills	_____	_____	_____
● Obesity Surgery	_____	_____	_____
● Registered Dietician	_____	_____	_____
● Weight loss retreat	_____	_____	_____
● Other: _____	_____	_____	_____

Have you maintained any weight loss for up to 1 year on any of these programs? YES NO

What did you learn from these programs regarding your weight? _____

What did not work about these programs? _____