Inside Out Weight Loss Program

Initial Evaluation Form—Medical and Emotional Wellness

Circle One: Employee Spouse Child SAP#_____

(All questions MUST be answered. Patients are NOT chosen on a first-come, first- served basis. The information you provide will NOT impact your health insurance. Only Allegiance Health Insurance patients can qualify.)

Name _____ Date of Birth _____ Age _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Occupation _____

Current Weight _____ Current Height _____ Sex: □ Male □ Female

At what age did you begin to develop a significant weight problem? _____

In your **opinion**, what contributes to your excess weight?

□ Portion sizes □ Eating too much fat and sugar □ Stress eating

□ Emotional eating □ Compulsive eating □ Lack of exercise

□ Medications (please list below) □ Lack of knowledge about healthful eating and exercise

Please describe any events you believe are related to your weight gain

_____

Lowest weight as an adult (and when)? _____ **Peak** adult weight (and when)? _____

Other significant weight **gain**? _____ Other significant weight **loss**? _____

Activity growing up: Involved in sports/athletics? □ Yes □ No

Which Sports/Activities? _____

Did your family have dinner together? □ Yes □ No

□ Meat & Potatoes □Pasta □Fried Food □ Fast Food Dessert □ Yes □ No

How many meals do you consume per day? _____

How many snacks do you consume per day? _____

Any food Intolerances, food allergies, food restrictions, special diet? Please list.

Current medications and supplements

Name	Dose	How often	Start Date	Vitamin/Mineral	OTC (Aspirin, etc)	OTC (Herbal)

Please list allergies to medications and your reaction

_____

_____

Current lifestyle

Please check the appropriate box:

□ Single □ Married □ Divorced □ Widow □ Significant Other

Do you live alone? □ Yes □ No

Do you have children? □ Yes □ No If yes, please list ages _____

Do your children live at home? □ Yes □ No □ N/A

Do you smoke? □ Yes □ No

If yes, number of packs per day _ number of years __When did you quit _____

Do you drink alcohol? ___How many drinks/day ____How often _____

Do you use illicit drugs? □ Yes □ No

If yes, please describe drug, method and frequency of use (e.g. IV, smoke, snort, etc) _____

Do you currently exercise regularly? □ Yes □ No

If yes, what exercise do you perform?_____

How many times per week? _____How long do you exercise each time? _____

Weight Loss History

If treatment was recommended, what have you tried in the past?

□ Lifestyle □ Medication □ Surgery

Lifestyle (Diet and Exercise)

Name of Program	Year Started	How long?	Start Weight	# of lbs lost	Time wt stayed off	# of lbs regained

Weight Loss Medications (Prescription, Over-the-counter, Herbal)

Name of Program	Year Started	How long?	Start Weight	# of lbs lost	Time wt stayed off	# of lbs regained

Have you had nutrition counseling? ☐ Yes ☐ No

If yes, please describe _____

Personal Medical History

□ Heart Disease □ Diabetes □ Sexual Dysfunction □ Kidney Disease

□ High Blood Pressure □ GI Disorder □ Polycystic Ovarian Syndrome □ Bariatric Surgery

□ High Cholesterol □ Gout □ Anemia (Gastric bypass, Lap Band)

□ Sleep Apnea □ Arthritis □ Clotting/Bleeding Disorder

□ Asthma □ Osteoporosis □ Cancer

□ Thyroid Disorder □ Urinary Incontinence □ Other _____

Are you currently on a diet for a medical reason? □ Yes □ No

Have you ever had surgery? □ Yes □ No

Please list ALL **surgical** procedures and the approximate date: _____

_____

_____

Are you receiving any psychiatric/psychological services at this time? □ Yes □ No

If yes, by whom_____

Are you currently being treated for depression? □ Yes □No

If yes, by whom _____

Have you ever been diagnosed with an eating disorder? □Yes □ No

If yes, please describe _____

Binge Eating and Purging (Please check the appropriate box to your response)

Aside from holiday feasts, have you ever eaten a large amount of food rapidly and felt that this eating incident was excessive and out of control afterward? □ Yes □ No

If you answered yes to the above question, how often have you engaged in this behavior during the last year? Please check one.

1. Less than once a month
2. About once a month
3. A few times a month
4. About once a week
5. About three times a week
6. Daily

Have you ever purged (used laxatives, diuretics, or induce vomiting) to control your weight?

□ Yes □ No

If you answered yes to the above question, how often have you engaged in this behavior during the last year? Please check one.

1. Less than once a month
2. About once a month
3. A few times a month
4. About once a week
5. About three times a week
6. Daily

Please feel free to use this space for any additional information.

_____

_____

What do you feel your weight may be holding you back from doing?

Approx. How much weight would you like to lose to help reach your goals?

Inside Out Weight Loss Program

COLLIER COUNTY MEDCENTER AGREEMENT

I, _____ (patient's full name), give the medical provider at the Collier County Med Center authority to work as an adjunct with my current Primary Care Physician in managing my medical care. This includes, but is not limited to, modifying my current medications as seen fit based on regular blood draws during the duration of the weight loss program.

_____ (patient's signature)

_____ Date (mm/dd/year)

_____ (provider's signature)

_____ Date (mm/dd/year)