RICHMOND WEIGHT LOSS

Patient Intake (page 1 of 2)

Patient Information

Date: ____________File #: (office use) _________

Name: ____________________________________

E-Mail :___________________________________

Phone:________________Cell:_______________

Address: __________________________________

______________________,________,____________

City State Zip

Sex:❑M ❑F Age: _____DOB:____/_____/_____

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

SSN:______________________________________

Occupation:_________________________________

Employer:__________________________________

Spouse's Name:_____________________________

Spouse's Employer: __________________________

Family Physician: ___________________________

Notes_____________________________

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How did you hear about us?

☐Referral from doctor:_____ __________

☐Referral from patient:_______________

☐Television channel:_________________

☐Internet website:___________________

☐Newspaper:_______________________

☐Other:_____________________________

Weight Loss

Height:________

Current Weight:______

Weight 1 year ago:________

How much do you want to lose? _______

Desired Completion Date:_____________

CASH Scale

Compulsions/Cravings: Feeling or urge to eat when not hungry. You are full. There is no food in sight. You get an urge to eat which cannot be repressed.

*Please Circle: **Never occurs 0--1--2--3--4--5--6--7--8--9--10 Constant**

Appetite: Feeling of hunger stimulated by sight, sounds, smells, or social cues. You recently ate and feel full. You walk into a room. There is food everywhere. It looks and smells good. Everyone is having fun. You:

*Please Circle: **Never eat more 0--1--2--3--4--5--6--7--8--9--10 Always eat more**

Satiety: A feeling of fullness acquired during eating. When you eat, you usually:

*Please Circle: **Leave food on plate 0--1--2--3--4--5--6--7--8--9--10 Eat more than you should**

Hunger: That feeling of a pain or ache in your stomach when really empty. This is a true pain or discomfort.

*Please Circle: **Never hungry 0--1--2--3--4--5--6--7--8--9--10 Constant hunger**

Level of importance you give to losing weight.

*Please Circle: **Not Important 0--1--2--3--4--5--6--7--8--9--10 Very Important**

Treatment History

History of previous treatment diets, other? ☐ Yes ☐ No If yes, please specify and why it didn't work for you?____

____

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RICHMOND WEIGHT LOSS

Patient Intake (page 2 of 2)

Social History

Exercise? ☐None ☐ Moderate ☐ Daily Children? ☐Yes ☐ No

Habits? ☐Smoking # packs_____ ☐ Alcohol # drinks_____ ☐ Coffee/Caffeine # cups_____

Current Medications/Vitamins/Hormones

____

____

Current Review of Systems

Normal	Problem Details	Normal	Problem Details
☐Musculoskeletal	___________________	☐Stomach	_____________________
☐General Health	___________________	☐Bladder	_____________________
☐Eyes	___________________	☐Blood	_____________________
☐Ears/Nose/Throat	___________________	☐Neurological	_____________________
☐Thyroid	___________________	☐Psychiatric	_____________________
☐Breathing	___________________	☐Skin	_____________________
☐Heart	___________________	☐Allergic	_____________________

Pregnant?☐Y ☐N Nursing? ☐Y ☐N

Past Surgical History

☐I DO NOT have a history of any previous surgeries.

Type of Surgery/Year/Surgeon?____

____

Past Medical History

Alcoholism	☐ Y ☐ N	Cong Heart Failure	☐ Y ☐ N	Lung Problems	☐ Y ☐ N
Anemia	☐ Y ☐ N	Coronary Art Dis	☐ Y ☐ N	Migraines	☐ Y ☐ N
Arthritis	☐ Y ☐ N	Diabetes	☐ Y ☐ N	Mononucleosis	☐ Y ☐ N
Asthma	☐ Y ☐ N	Emphysema	☐ Y ☐ N	Multiple Sclerosis	☐ Y ☐ N
Atrial Fibrillation	☐ Y ☐ N	Epilepsy/Seizure	☐ Y ☐ N	Osteoporosis	☐ Y ☐ N
Birth Defects	☐ Y ☐ N	Gout	☐ Y ☐ N	Pacemaker	☐ Y ☐ N
Bladder Problems	☐ Y ☐ N	Headaches	☐ Y ☐ N	Parkinson's	☐ Y ☐ N
Blood Clots-legs	☐ Y ☐ N	Heart Disease	☐ Y ☐ N	Prostate Issues	☐ Y ☐ N
Blood Clots-lungs	☐ Y ☐ N	Hemophilia	☐ Y ☐ N	Psychological Dis	☐ Y ☐ N
Blood Pressure-high	☐ Y ☐ N	Hepatitis A / B / C	☐ Y ☐ N	Recurrent Infection	☐ Y ☐ N
Blood Pressure-low	☐ Y ☐ N	Hernia	☐ Y ☐ N	STD	☐ Y ☐ N
Bowel Issues	☐ Y ☐ N	Herpes	☐ Y ☐ N	Stroke CVA / TIA	☐ Y ☐ N
Cancer	☐ Y ☐ N	HIV/AIDS	☐ Y ☐ N	Thyroid	☐ Y ☐ N
Cancer Remission	☐ Y ☐ N	Kidney/Renal Dis	☐ Y ☐ N	Ulcer	☐ Y ☐ N
How long in Remission? ______		Liver Disease	☐ Y ☐ N	Other _____________________	

By signing below, you assume full responsibility to inform Integrative Health, LLC d/b/a Richmond Weight Loss of any changes in medical status.

Patient Signature: ____Date: _________________