LONGSTREET CLINIC
Center for Weight Management

DATE: _____

Medically Supervised Weight Loss

DEMOGRAPHICS

_____ _____
NAME **EMAIL**

_____ _____
Address **Phone**

_____ _____ _____
Date of Birth **Marital Status** **Highest level of Education Completed**

_____ _____
EMERGENCY CONTACT **PHONE**

WEIGHT HISTORY

_____ _____ _____ _____
CURRENT WEIGHT **HEIGHT** **WHAT IS YOUR GOAL WEIGHT?** **WHEN DID YOU LAST WEIGH THIS AMOUNT?**

Indicate ages you were overweight CHILDHOOD (2-11 yrs) ADOLESCENCE (12-19 yrs) Age 20-29yrs Age 30-40 yrs Over 40 yrs

HOW MUCH WEIGHT DO YOU EXPECT TO LOSE WITH THIS PROGRAM? _____

Have you ever had any type of weight loss surgery? YES NO

Which weight loss methods have you tried in the past? Please be specific as possible

WEIGHT LOSS METHOD	HOW LONG WAS LOSS MAINTAINED	WHY DID YOU STOP TREATMENT	PROBLEMS DURING TREATMENT
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Which weight loss method do you consider the most successful? _____

What accounted for this success? _____

MEDICAL HISTORY

Primary Care Physician:

Name/Phone

Referring Physician:

Name/Phone

When was your most recent complete physical exam? Month: Year:

CURRENT MEDICATIONS

Name	Dosage	How Often

ALLERGIES TO MEDICATIONS _____

PAST MEDICAL HISTORY (Please check all that apply)

_____ Heart Disease
_____ High Blood Pressure
_____ Diabetes/Pre-diabetes
_____ Renal/Kidney Disease
_____ Cancer
_____ Kidney Stones
_____ Heartburn or reflux (GERD)
_____ Inflammatory Bowel Disease
_____ Fatty Liver Disease
_____ High Cholesterol/Triglycerides
_____ Sleep Apnea/Sleep Disorders
_____ Blood Clot/DVT
_____ Osteoarthritis
_____ Issues with Infertility
_____ Depression/Anxiety and any medications tried in the past _____
_____ Other (please explain) _____

WOMEN ONLY

Onset of first period _____ Are you currently pregnant or planning to become pregnant within 6 months _____

Are your periods regular _____ Number of pregnancies _____ Number of Miscarriages _____

Date of most recent menstrual period _____ Have you Completed Menopause _____ Are you Perimenopausal _____

Weight gain with pregnancies _____ lbs Do you or have you ever used contraceptives _____ What type _____

MEN ONLY

Age at onset of Puberty _____

PSYCHOSOCIAL HISTORY

Are you presently undergoing any major lifestyle changes? Marriage Divorce Job Change Death of someone important to you

Other? _____

What benefits do you hope to gain from being in this program other then weight loss? _____

Who do you think will be supportive of your weight loss and changes in your lifestyle? _____

Who do you feel may not be supportive of your weight loss and changes in your lifestyle? _____

What are your 5 top reasons for wanting to lose weight?

1. _____
2. _____
3. _____
4. _____
5. _____

Why did you choose this particular program? _____

Are you currently in any type of psychotherapy? **YES** **NO** Have you ever been in psychotherapy before?_____

With Whom? _____ For What? _____ Date Treatment Began? _____

Have you ever been hospitalized for psychiatric treatment? **YES** **NO**
Please Specify _____

Have you ever experienced suicidal thoughts? **YES** **NO** Have you ever been severely depressed? **YES** **NO**

Have you ever experienced dramatic mood changes during dieting? (Especially anxiety or depression) **YES** **NO** **POSSIBLY**

Do you have a history of abuse? **VERBAL** **PHYSICAL** **SEXUAL**

Do you ever been diagnosed with or concerned that you had an eating disorder? **ANOREXIA** **BULIMIA** **BINGE EATING**

PURGING **OUT OF CONTROL EATING** **OTHER** _____

What are your triggers for eating? **STRESS** **DEPRESSION** **BOREDOM** **OTHER** _____

Is there a history of obesity in your parents? YES NO Whom? _____

How many hours a day do you spend sitting? _____ Number of hours of screen time (TV/COMPUTER/TABLETS/PHONE)

LIFESTYLE AND EATING HABITS

Do you drink alcohol? YES NO Monthly Weekly More than once weekly Daily More than 1 drink per day

Do you smoke? YES NO Have you ever been a smoker? YES NO Packs per Day _____ **Year Quit** _____

How often do you exercise? Never Rarely Occasionally 1-2 times per week 3-4 times per week 5 or more times weekly

Has a doctor or health professional ever told you not to exercise? **YES NO** Do you know of any reason you should not exercise? **YES NO**

If you answered yes to either question please explain : _____

How many hours do you sleep each night? _____ Is it restful? Do you wake refreshed? _____

Number of meals you eat per day _____ **Number of snacks per day** _____

Do you snack after dinner _____ **How many meals do you eat out per week?** _____

Of the meals you eat out – How many are fast food? _____ **How many are in restaurants/cafeterias?** _____

Are the majority of these meals with friends? _____ **What is your WATER intake daily?** _____

Number of sugar sweetened beverages daily (Fruit Juice/Soda/Gatorade/Powerade, etc.) ? _____

Number of diet drinks daily? _____ **Glasses of whole milk daily?** _____

Who does the cooking at home? _____ **Do you take a Multivitamin?** _____ **Brand?**_____

Any food allergies? Please List _____

What is one behavior you want to change right now? _____

_____

I certify that the information on this form is true and correct to the best of my knowledge.

_____ _____

Signature Date

I give permission for the data provided in this from and obtained in subsequent visits and interviews to be submitted for the purpose of group evaluation of data. Except for the purpose of matching current and future data, my name will not be used in conjunction with any of the data. I understand that such group evaluation may, from time to time, be used in publications or other materials, but that participant confidentiality will be maintained.

_____ _____

Signature Date

FOR OFFICE USE ONLY

The Epworth Sleepiness Scale

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0, no chance of dozing, to 3, high chance of dozing. When you finish the test, add up the values of your responses. Your total score is based on a scale of 0 to 24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

How Sleepy Are You?
How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

- No chance of dozing =0
- Slight chance of dozing =1
- Moderate chance of dozing =2
- High chance of dozing =3

Write down the number corresponding to your choice in the right hand column. Total your score below.

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting inactive in public place (e.g., a theater or a meeting)	
As a passenger in a car for a hour without a break	
Lying down to rest in the afternoon if circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

Total Score = _____

Analyze Your Score

Interpretation:

0-7: It is unlikely that you are abnormally sleepy.
8-9: You have an average amount of daytime sleepiness.
10-15: You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention. Poor sleep can contribute to weight gain.
16-24: You are excessively sleep and should consider seeking medical attention.

For each question, circle the answer that best describes how you feel.

Section 1: Goals and Attitudes

1. Compared to previous attempts, how motivated to lose weight are you this time?

1	2	3	4	5
Not At All Motivated	Slightly Motivated	Somewhat Motivated	Quite Motivated	Extremely Motivated

2. How certain are you that you will stay committed to a weight loss program for the time it will take to reach your goal?

1	2	3	4	5
Not At All Certain	Slightly Certain	Somewhat Certain	Quite Certain	Extremely Certain

3. Consider all outside factors at this time in your life (the stress you're feeling at work, your family obligations, etc). To what extent can you tolerate the effort required to stick to a diet?

1	2	3	4	5
Cannot Tolerate	Can Tolerate Somewhat	Uncertain	Can Tolerate Well	Can Tolerate Easily

4. Think honestly about how much weight you hope to lose and how quickly you hope to lose it. Figuring a weight loss of 1 to 2 pounds per week, how realistic is your expectation?

1	2	3	4	5
Very Unrealistic	Somewhat Unrealistic	Moderately Unrealistic	Somewhat Realistic	Very Realistic

5. While dieting, do you fantasize about eating a lot of your favorite foods?

1	2	3	4	5
Always	Frequently	Occasionally	Rarely	Never

6. While dieting, do you feel deprived, angry and/or upset?

1	2	3	4	5
Always	Frequently	Occasionally	Rarely	Never

Section 1 TOTAL SCORE _____

Section 2: Hunger and Eating Cues

7. When food comes up in conversation or in something you read, do you want to eat even if you are not hungry?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

8. How often do you eat because of physical hunger?

1	2	3	4	5
Always	Frequently	Occasionally	Rarely	Never

9. Do you have trouble controlling your eating when your favorite foods are around the house?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

Section 2 TOTAL SCORE _____

Section 3: Control Over Eating

If the following situations occurred while you were on a diet, would you be likely to eat **more** or **less** immediately afterward and for the rest of the day?

10. Although you planned on skipping lunch, a friend talks you into going out for a midday meal.

1	2	3	4	5
Would Eat Much Less	Would Eat Somewhat Less	Would Make No Difference	Would Eat Somewhat More	Would Eat Much More

11. You "break" your diet by eating a fattening, "forbidden" food.

1	2	3	4	5
Would Eat Much Less	Would Eat Somewhat Less	Would Make No Difference	Would Eat Somewhat More	Would Eat Much More

12. You have been following your diet faithfully and decide to test yourself by eating something you consider a treat.

1	2	3	4	5
Would Eat Much Less	Would Eat Somewhat Less	Would Make No Difference	Would Eat Somewhat More	Would Eat Much More

Section 3 TOTAL SCORE _____

Section 4: Binge Eating and Purging

13. Aside from holiday feasts, have you ever eaten a large amount of food rapidly and felt afterward that this eating incident was excessive and out of control?

2	0
Yes	No

14. If you answered yes to #13, how often have you engaged in this behavior during the last year?

1	2	3	4	5	6
Less Than Once A Month	About Once A Month	A Few Times A Month	About Once A Week	About Three Times A Week	Daily

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

5	0
Yes	No

16. If you answered yes to #15 above, how often have you engaged in this behavior during the last year?

1	2	3	4	5	6
Less Than Once A Month	About Once A Month	A Few Times A Month	About Once A Week	About Three Times A Week	Daily

Section 4 TOTAL SCORE _____

Section 5: Emotional Eating

17. Do you eat more than you would like to when you have negative feelings such as anxiety, depression, anger or loneliness?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

18. Do you have trouble controlling your eating when you have positive feelings - do you celebrate feeling good by eating

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

19. When you have unpleasant interactions with others in your life, or after a difficult day at work, do you eat more than you'd like?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

Section 5 TOTAL SCORE

Section 6: Exercise Patterns and Attitudes

20. How often do you exercise?

1	2	3	4	5
Never	Rarely	Occasionally	Somewhat	Frequently

21. How confident are you that you can exercise regularly?

1	2	3	4	5
Not At All Confident	Slightly Confident	Somewhat Confident	Highly Confident	Completely Confident

22. When you think about exercise, do you develop a positive or negative picture in your mind?

1	2	3	4	5
Completely Negative	Somewhat Negative	Neutral	Somewhat Positive	Completely Positive

23. How certain are you that you can work regular exercise into your daily schedule?

1	2	3	4	5
Not At All Certain	Slightly Certain	Somewhat Certain	Quite Certain	Extremely Certain

Section 6 TOTAL SCORE