Health Appraisal

Please complete all information to the best of your ability

Patient Information

Legal Name (Last, First, Middle) _____ Preferred Name: _____

Cell # (____) _____-_____Home # (____) _____-_____ Email Address_____

YES! I would like to receive ☐ Email Reminders ☐ Text Reminders Cellular Carrier: _____

Address _____City _____ State _____ Zip _____

Occupation_____ Employer_____ Office # (____) _____-_____

Sex M/F Birth Date____/____/____ Age _____ S.S.#___-_____ Marital Status M S W D

Name of Spouse _____ Occupation _____ Employer_____

Emergency Contact:

Name _____ Relation _____ Cell # (____) _____-_____Work # (____) _____-_____

Primary Care Physician (PCP) _____ Last Visit ____/____/____ Office # (____) _____-_____

Address _____City _____ State _____ Zip _____

Are you currently undergoing treatment for any medical condition? Y / N Condition _____

Treating Physician _____ Last Visit ____/____/____ Office # (____) _____-_____

Have you been cleared by your PCP to participate in a weight loss program? Y / N To begin an exercise program? Y / N

I authorize this office to communicate with my Primary Physician about my care and the results I receive in this office.

Signature: _____ Date: ____/____/____

Who may we thank for referring you?

Name: _____ ☐ Patient/Friend ☐ Doctor ☐ Gym ☐ Internet ☐ Ad Other _____

Parent/Legal Guardian (Complete if patient is under the age of 18 or otherwise unable to consent to treatment):

Signing below will allow our office to evaluate the above patient.

Name: _____ Signature: _____ Date: ____/____/____

What brings you into our office? (in order of importance):

1. _____Date First Appeared____/____/____
2. _____Date First Appeared____/____/____
3. _____Date First Appeared____/____/____

Have you had the same or similar problem (s) before? ___Yes ___ No When: _____

Do you have a family member with the same problems? _____ If so, who? _____

Other doctors you have seen for this problem (s) _____

Surgeries you have had for this condition? _____

What are your health goals?

Long Term 1. _____ 2. _____3. _____

Short Term 1. _____ 2. _____3. _____

What is your current level of commitment to reach your goal? _____

Subjective Health Assessment

Please rate the following symptoms that you have experienced during the ***last 30 days***
0 = Never **1** = Occasional and Mild **2** = Occasional and Severe **3** = Often and Mild **4** = Often and Severe

Head

0 1 2 3 4	Headache	
0 1 2 3 4	Faintness	
0 1 2 3 4	Dizziness	
0 1 2 3 4	Sleeplessness	___Total

Eyes, Ears, Nose, Throat

0 1 2 3 4	Stuffy Nose	
0 1 2 3 4	Sinus Trouble	
0 1 2 3 4	Hay Fever	
0 1 2 3 4	Sneezing	
0 1 2 3 4	Nasal Congestion	
0 1 2 3 4	Swollen Eyes	
0 1 2 3 4	Reddened Eyes	
0 1 2 3 4	Watery, Itchy Eyes	
0 1 2 3 4	Dark Circles Under Eyes	
0 1 2 3 4	Earache, Ear Infection	
0 1 2 3 4	Ringing in the Ears	
0 1 2 3 4	Coughing	
0 1 2 3 4	Sore Throat	
0 1 2 3 4	Hoarseness, Loss of Voice	
0 1 2 3 4	Canker Sore	___Total

Memory, Emotions

0 1 2 3 4	Mood Swings	
0 1 2 3 4	Anxiety, Nervousness	
0 1 2 3 4	Anger, Irritability	
0 1 2 3 4	Aggressiveness	
0 1 2 3 4	Depression	
0 1 2 3 4	Poor Memory	
0 1 2 3 4	Confusion	
0 1 2 3 4	Lack of Concentration	
0 1 2 3 4	Difficulty in Making Decisions	___Total

Heart, Lungs

0 1 2 3 4	Irregular Heart Beat	
0 1 2 3 4	Rapid, Pounding Heart Beat	
0 1 2 3 4	Chest Pain	
0 1 2 3 4	Chest Congestion	
0 1 2 3 4	Asthma	
0 1 2 3 4	Bronchitis	___Total

Skin

0 1 2 3 4	Acne	
0 1 2 3 4	Dry, Scaly Skin	
0 1 2 3 4	Hair Loss	
0 1 2 3 4	Hot Flashes	___Total

Digestion

0 1 2 3 4	Nausea, Vomiting	
0 1 2 3 4	Diarrhea	
0 1 2 3 4	Constipation	
0 1 2 3 4	Heartburn	
0 1 2 3 4	Stomach Pain	
0 1 2 3 4	Bloating	
0 1 2 3 4	Belching, Gas	___Total

Joints

0 1 2 3 4	Stiffness/Lack of Motion	
0 1 2 3 4	Arthritis	
0 1 2 3 4	Pain in the Joints	
0 1 2 3 4	Pain in the Muscles	___Total

Energy Levels

0 1 2 3 4	Weakness	
0 1 2 3 4	Fatigue	
0 1 2 3 4	Hyperactivity	
0 1 2 3 4	Restlessness	___Total

Weight

0 1 2 3 4	Binge Eating/Drinking	
0 1 2 3 4	Craving Certain Foods	
0 1 2 3 4	Excessive Weight	
0 1 2 3 4	Water Retention	
0 1 2 3 4	Overweight	___Total

Grand Total _____

1. In general would you say your health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

2. *Compared to one year ago, how would you rate your health in general now verse one year ago?*

☐ Much better ☐ Somewhat better ☐ About the same ☐ Much worse

3. The following items are about activities you might do during a typical day. Does *your health now limit you* in these activities? If so, how much? ☐ Yes, Limited a lot ☐ Yes, Limited a little ☐ No, Not limited at all

4. During the *past 4 weeks* have you had any of the following problems with your work or other regular daily activities *as a result of your physical health*?

a. ☐ Yes ☐ No Cut down the *amount of time* you spent on work or other activities.
b. ☐ Yes ☐ No *Accomplished* less than you would like.
c. ☐ Yes ☐ No Were limited in the *kind* of work or other activities.
d. ☐ Yes ☐ No Had difficulty performing at work or other activities (for example, it took extra effort).

5. During the past *4 weeks*, have you had any of the following problems with your work or other regular activities *as a result of any emotional problems* (such as feeling depressed or anxious)?

a. ☐ Yes ☐ No Cut down the *amount of time* you spent on work or other activities.
b. ☐ Yes ☐ No *Accomplished* less than you would like.
c. ☐ Yes ☐ No Were limited in the *kind* of work or other activities.
d. ☐ Yes ☐ No Had difficulty performing at work or other activities (for example, it took extra effort).

6. During the past *4 weeks* to what extent has your physical health, emotional problems interfered with your normal social activities with family, friends, neighbors or groups? ☐ Not at all ☐ Slightly ☐ Moderately ☐ Severe ☐ Very severe

7. How much bodily *pain* have you had during the *past 4 weeks*? ☐ None ☐ Very mild ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

8. During the *past 4 weeks*, how much did *pain* interfere with your normal work (including both work outside the home and housework)?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

9. These questions are about how you feel and how things have been with you *during the past 4 weeks*. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time *during the past 4 weeks:* *(Check one box next to each question)*	**All of the time**	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
Did you feel full of pep?					
Have you been a nervous person?					
Have you felt so down in the dumps that nothing could cheer you up?					
Have you felt calm and peaceful?					
Did you have a lot of energy?					
Have you felt downhearted or blue?					
Did you feel worn out?					
Have you been a happy person?					
Did you feel tired?					

10. During the *past 4 weeks* how much of the time has your *physical health or emotional problems* interfered with you social activities (like visiting either friends, relatives, etc.)?

☐ All the time ☐ Most of the time ☐ Some of the Time ☐ A little of the time ☐ None of the time

11. How TRUE or FALSE is *each* of the following statements for you?

a. I seem to get sick easier than other people
☐ Definitely true ☐ Mostly true ☐ Don't know ☐ Mostly false ☐ Definitely falseb.

b. I am as healthy as anybody I know
☐ Definitely true ☐ Mostly true ☐ Don't know ☐ Mostly false ☐ Definitely false

c. I expect my health to get worse
☐ Definitely true ☐ Mostly true ☐ Don't know ☐ Mostly false ☐ Definitely false

d. My health is excellent
☐ Definitely true ☐ Mostly true ☐ Don't know ☐ Mostly false ☐ Definitely false

Health History

Please insert age in the first column and check any box that applies in each of the following columns.

	Age (if living)	Heart Dx	High Chol.	High Bl. Pressure	Diabetes	Cancer (type)	Anemia	Neck Pain	Back Pain	Head aches	Obesity
Self											
Mom											
Dad											
Brother											
Sister											

Lifestyle

Please answer the following questions by circling yes or no and provide explanations when requested.

Y / N	a. Do you smoke? If yes, how many packs a day? _____
Y / N	b. Do you drink alcohol? If yes, how many drinks a week? _____
Y / N	c. Do you drink caffeinated beverages? If yes, what kind and how many daily? _____
	d. How many 8oz glasses of water do you drink per day: _____ What kind? Tap Filtered Distilled RO
	e. How many times do you eat fast food each week? _____
	f. How many servings of fruits & vegetables are you eating daily? 0 1 2 3 4 5 6 7 8 9 10 1 medium fruit = 1 serving 1 cup raw vegetables = 1 serving
Y / N	g. Do you think you need to take vitamin supplementation?
Y / N	h. Are you currently taking a multivitamin? If yes, please name: _____
Y / N	i. Are you presently or have you ever been on blood thinning medication?
	j. What level of stress do you experience daily? 1 2 3 4 5 6 7 8 9 10
Y / N	k. Are you at your ideal weight? If no: What is your current Weight? _____ Desired weight? _____
Y / N	l. Do you engage in any cardiovascular exercise (e.g., aerobics, walking, etc.)? If so, which activities?_____ m. How many days per week? _____ For how long? _____ hours _____ minutes
Y / N Unsure	n. Do you reach your target heart rate? MALE: 220-AGE = MAX (Target 60-70%) FEMALE: 226-AGE = (Target 60-70%)
Y / N	o. Do you ever experience pain after exercising? If so, where? _____

SUPPLEMENTATION
List all supplements you are currently taking.
MEDICATIONS
List all prescriptions you are currently taking.
WOMEN ONLY
1. Y / N Are you pregnant or planning a pregnancy? 3. Y / N Have you had a hysterectomy? 2. Y / N Are you taking birth control? 4. Y / N Are you taking estrogen replacement therapy?

Terms of Acceptance for Nutritional Care

We solely provide any suggested nutritional advice or dietary advice, and the adjunctive schedule of nutrition to upgrade the quality of foods and nutrients in your diet and to support the healthy function of your body.

We may use laboratory testing to find dysfunction in the organ systems of the body. We will not use any of the diagnostic testing to diagnose and/or treat disease, but only to enhance the function of the human body. Regardless of what the disease is called, we do not offer to treat it.

A vitamin, mineral, trace element, amino acid or herb is not a drug. Although any of these substances may have an effect on any disease process or symptom, this does not mean that anyone can be misrepresent or classify them as drugs.

The goal of our nutritional care is to increase your body's ability to function optimally.

I understand *the objectives pertaining to my nutritional care in this office. Therefore, I accept nutritional care on this basis.*

Name: _____ Signature: _____ Date: ____/____/____

Financial Arrangement

Our office has conservative fees and comfortable payment arrangements. We want to make sure that our patients are able to receive the needed care in an affordable manner. All services must be paid at the time of service. If alternate payment arrangements are needed, this must be discussed before services are rendered. However, we will discuss all fees before any services are provided.

I have read and understand the statements above.

Name: _____ Signature: _____ Date: ____/____/____

Patient Privacy Consent

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT ANALYSIS, TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

I, _____ hereby state that by signing this consent, I acknowledge and agree as follows:

___ 1. The practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide analysis and treatment for me, and also necessary for the practice to obtain payment for that treatment and to carry out its healthcare operations. The practice explained to me that the privacy notice would be available to me in the future at my request. The practice has encouraged me to read the privacy notice carefully prior to signing this consent.

____ 2. The practice reserves the right to change its privacy practices that are described in its privacy notice, in accordance with applicable law.

____ 3. I understand that, and consent to, the following appointment reminders that will be used by the practice:
Postcards mailed to the addresses I have provided. Telephoning me at the numbers I have provided and leaving messages for me on my answering machine or with the individual answering the phone.

____ 4. The practice may use and/or disclose my PHI (which includes information about my health or condition, analysis, and the treatment provided to me) in order for the practice to make analyses about my condition(s), treat me, obtain payment for that treatment, and as necessary for the practice to conduct its specific health care operations.

____ 5. I understand that I have the right to request that the practice restrict how my PHI is used and/or disclosed except to obtain payment for treatment provided. However, the practice is not required to agree to any restrictions that I have requested, and I have the right to refuse treatment.

____ 6. I understand that this consent is valid as long as I am a patient in this office. I further understand that I have the right to revoke this consent, in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent. If I revoke this consent at any time, the practices has the right to refuse to treat me.

I have read and understand the above statements. I understand that I have the right to refuse to sign this authorization. If I choose to decline signing this consent form, this practice will not treat me.

Date: ____/____/____ Patient DOB: ____/____/____

If you indicated weight loss is one of your health goals please answer the following questions

General

What is the main reason you decided to lose weight? _____
What do you think is the main cause of your weight problems? _____
When did you begin gaining excess weight? Provide reasons, if known. _____
Is your significant other overweight? If so, by how much? _____
How would you describe your body? _____
What do you feel your obstacles will be to successful weight loss? _____
What do you believe to be the most effective weight loss strategy? _____

Food Habits

Please describe your previous attempts at weight loss by providing as much information as possible.
Date: ____/____/____ Method and Results: _____
Date: ____/____/____ Method and Results: _____
Date: ____/____/____ Method and Results: _____
What foods do you avoid? _____
What foods do you crave? What do you do when you are having cravings? _____
What are your worst food habits? _____
Do you wake up hungry during the night? Y / N If so, what do you do? _____
How many times per week do you dine out? _____ What restaurants do you frequent? _____
_____
What types of foods do you eat there? _____
List any food allergies _____
Who plans meals/cooks/shops? _____
Do you use a shopping list when you buy groceries? _____

Please fill out the chart below to indicate your typical meal patterns

	Type of foods	Time of Day	Location	Who you eat with
Breakfast				
Lunch				
Dinner				

Life Effect

How do your weight problems affect other areas of your life? (Social, Emotional, Family, Professional, Mental, Financial)
_____
How do you imagine your life will improve once you reach your weight loss goal? _____
If you could change one thing about your body what would it be? _____
Describe what your body would look like if you met your overall weight loss goal. _____
_____
Please rate the following in the last 30 days:

My #	Quality of Life	Excellent	Very Good	Good	Average	Fair	Poor
	Sleep	5	4	3	2	1	0
	Mood	5 	4 	3 	2 	1 	0 
	Energy	5	4	3	2	1	0
	Chronic Pain	5 No Pain	4	3	2	1	0 Severe Pain