ASSOCIATES IN WOMEN'S HEALTH

obgyn specialists

Metabolic Health and Wellness Intake Form

Name: **Date of Birth:**

Past Medical and Weight History

Please circle if you have ever been diagnosed with any of the following (please include if it happened during pregnancy):

Diabetes	Kidney Disease	Reflux or Heartburn
Gestational Diabetes	Infertility	Liver Disease
High blood pressure	Sleep Apnea	Gout
Heart Disease	High Cholesterol	Eating Disorder
PCOS	Gallstones	Thyroid Disease

Why are you are seeking treatment at this time?

What is the single most important outcome for you as we start this journey?

How long have you struggled with your weight?

Have you tried in the past to lose weight? If so, what did you try? What works for you? What doesn't?

Does anyone in your family struggle with obesity or overweight?	Yes	No
Does your weight affect the way you feel about yourself?	Yes	No
Have you ever been on a weight loss medication?	Yes	No
Have you ever had weight loss surgery?	Yes	No
Are you interested in weight loss surgery?	Yes	No
Are you interested in anti-obesity medications?	Yes	No

Lifestyle

What time do you wake up: What time do you go to sleep:

On average, over the past month, how many hours of sleep do you get per night?

Do you feel rested when you wake up?	Yes	No
Do you snore loudly? (louder than talking or loud enough to be heard through closed doors)	Yes	No
Has anyone observed you stop breathing during your sleep?	Yes	No
Do you require an alarm to wake up?	Yes	No

Rate your stress in your life (circle your answer, 0 being low, 5 being high)

0 1 2 3 4 5

What do you do to relax/What are your hobbies?

Do you feel like you cope with your stress okay?

Who currently lives in your home with you?

Nutrition

How would you describe your eating style?

Who does the grocery shopping? Where? How often?

Who cooks the food in your house? Do you like to cook?

How often per week do you eat out? Where do you tend to go most often?

Do you have any specific nutrition needs? I.E. vegetarian

Is there a time of day that you find that you eat more, or have trouble choosing healthier food options?

How many meals/snacks per day do you have fruits and/or vegetables?

Do you **Typically** eat until you feel stuffed or uncomfortable? If so, how often?

If applicable, what triggers episodes of overeating for you?

Do you read nutrition labels?	Yes	No
Do you eat differently on days that you work vs day you do not work?	Yes	No
Do you feel hungry **immediately** after you finish a meal?	Yes	No
Do you feel hungry **in-between** meals?	Yes	No
Do you wake up in the middle of the night to eat?	Yes	No
Do you eat in secret?	Yes	No
Are you satisfied with your eating patterns?	Yes	No
Do you feel out of control when you eat?	Yes	No

How much of the following do you drink a day?

	Amount		Amount
Juice		Milk	
Soda/diet soda		Sports Drinks	
Coffee		Water/sparkling water	
Alcohol		Other	

Any other nutrition comments, concerns, or questions that you want to share?

Physical Activity

What types of physical activities do you enjoy? (Ex: gardening, cleaning, walking, etc.)

How often do you participate in those activities?

On a typical day, which describes you? (circle your answer)

Mostly sitting

Mostly moving/walking

Mostly heavy labor

Unsure, other

What has been your experience with exercise or physical activity?
Ex: do you enjoy/hate it? Do it regularly? Any negative feelings or bad experiences?

Do you have a gym membership?	Yes	No
Do you have exercise equipment at home?	Yes	No
Do you have any family members or friends who are willing to encourage you to exercise or possibly exercise with you?	Yes	No
Would you like to change your physical activity habits?	Yes	No

If yes, how confident are you that you could change them?

0 1 2 3 4 5

What barriers to you face in changing your physical activity? Circle all that apply:

I don't have enough time

I get embarrassed when I try to exercise

I have no place to exercise

I have physical problems that make it hard

Exercise is very unpleasant for me

Exercise is too expensive

Other:

How much time are you willing to commit to physical activity?

Minutes per day	Days per week

How much time do you spend doing the following each day?

	Hours per day
Watch TV	
Sit at a computer	
Use your phone	

Food Insecurity Screening

How true have the following statements been for you in the past 12 months:

	Often True	Sometimes True	Never True
We worried whether our food would run out before we got money to buy more.			
The food that we bought just didn't last, and we didn't have money to get more.			

Do you get food through WIC or food assistance?

Par-Q Physical Activity Screening

Has your doctor ever said that you have a heart condition or high blood pressure?

Do you feel pain in your chest at rest, during your daily activities of living or when you do physical activity?

Do you lose balance because of dizziness or have you lost consciousness in the last 12 months? Please answer NO if your dizziness was associated with over-breathing(including during vigorous exercise).

Do you currently or have had within the past 12 months, a bone, joint or soft tissue muscle, ligament or tendon problem that could be made worse by becoming more physically active?

Has your doctor ever said that you should only do medically supervised physical activity?