



INFINITE HEALTH CENTERS

25% BF= _____

20% BF= _____

Current Weight: _____ Desired Weight: _____ Date: _____

*****How did you hear about us?**

TV: _____ **Internet:** _____ **Newspaper:** _____ **Radio:** _____

*****If someone referred you who may we**

Thank?

Weight loss can be complex. If you have failed in the past, it could be because you have some of the following (Check All that Apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Gas after a meal | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Difficulty getting to sleep | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Difficulty staying asleep | <input type="checkbox"/> Sugar Cravings | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> High amounts of stress | <input type="checkbox"/> Irritable if meals are missed | <input type="checkbox"/> Hip pain |
| <input type="checkbox"/> Over heating | <input type="checkbox"/> Fatigue after meals | <input type="checkbox"/> Take pain medication |
| <input type="checkbox"/> Cold hands and feet | <input type="checkbox"/> Fibromyalgia | |
| <input type="checkbox"/> Low sex drive | <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Mental fatigue | |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Menopause | |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Muscle pain | |

Please list any of the major health concerns in order of importance

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

Please list any food allergies

1. _____
2. _____

Previous Weight Loss Plans and / or surgeries

| | | |
|-----------------|----------|----------|
| Office Use ONLY | | |
| 1 | 2 | 3 |

Health Assessment

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone (Cell): _____ Phone (Home/Work): _____

Date of Birth: ___/___/___ Age: _____ Sex: _____ Race: _____

Email Address (Please Print) _____

Current Height: _____ Weight: _____ Weight 1 Year Ago: _____

Lowest Adult Weight: _____ At what Age? _____ How long maintained? _____

Lowest Adult Weight Maintained for > 1 year _____ At what age? _____

What is your personal goal weight this time? _____ lbs

How many times have you intentionally lost 20lbs or more and gained it all back?

Never ____ Once or twice ____ 3-4 Times ____ 5+ Times ____

***Have you ever been Diagnosed with an Eating Disorder? Yes or Nolf Yes, what type? _____**

Do you exercise? Yes or No Frequency per week? _____ Hrs or mins per session _____

How long have you been exercising? _____ What type of exercise do you do? _____

Check all that Apply:

| | |
|---|--|
| <input type="checkbox"/> I eat when I am not hungry. | <input type="checkbox"/> I can over eat almost any food. |
| <input type="checkbox"/> I sometime eat much faster and/or much more than others. | <input type="checkbox"/> I graze or snack frequently between meals |
| <input type="checkbox"/> I isolate from others so I can eat the way I want. | <input type="checkbox"/> I am obsessive about the way I think about food. |
| <input type="checkbox"/> I sometimes think I will Eat moderately and then eat much more than I expected to eat. | <input type="checkbox"/> I think weight causes me serious physical and social problems and I still overeat |
| <input type="checkbox"/> I use food to numb difficult feelings | <input type="checkbox"/> I have tried to stop bingeing and been unable to stay stopped |

Medical Diagnosis: (Have you ever been Diagnosed with Anything?)

| Year | Reason |
|------|--------|
| | |
| | |
| | |
| | |

List All Current Medications and Supplements Including Name, Frequency, and Dose (Include hormones and birth control pills.)

| Name of Medication | Dose | Frequency | | Name of Medication | Dose | Frequency |
|--------------------|------|-----------|--|--------------------|------|-----------|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Do you Smoke Cigarettes? _____ (Y/N) If Yes, # per day _____ For how long? _____
 Do you Drink Alcohol? _____ (Y/N) If yes, How Much/Quantity per Week? _____
 Have you ever participated in Counseling or Psychotherapy? (Y/N) _____
 If yes, Whom _____
 Type: Individual: _____ Family _____ Couples _____ Substance abuse _____

Check if YOU have or had any of the following:

| Condition | Check | Condition | Check | Condition | Check |
|--------------------------------|-------|-----------------------|-------|---------------------|-------|
| Cancer (Active) | | Asthma | | Irregular Heartbeat | |
| Diabetes | | Anemia | | Phlebitis | |
| Kidney Disease (Dialysis) ESRD | | Chest Pain | | Low Back Pain | |
| Severe Depression | | Chronic Diarrhea | | Epilepsy | |
| Celiac | | Chronic Constipation | | Seizures | |
| Heart Disease | | Fainting | | Shortness of Breath | |
| Liver Disease | | Frequent Headaches | | Sleep Difficulties | |
| Kidney Disease (Non-Dialysis) | | Frequent Nausea | | Stroke | |
| | | Gallbladder Disease | | Swelling of Feet | |
| Cancer (Previously) | | Gout | | Thyroid Disease | |
| High Blood Pressure | | Heartburn Allergies | | Ulcers | |
| High Cholesterol | | Dizziness | | Yellowing | |
| Lap band | | Arthritis | | Hemorrhoids | |
| Gastric Bypass | | Alcoholism/Drug Abuse | | Neuropathy | |
| Anxiety/Panic Attacks | | Mild Depression | | | |

For Women Only: Please check ALL that Currently Apply

| | | | | | |
|--------------------|--|-------------------------------------|--|---|--|
| Do you have an IUD | | Do you take Birth Control | | Hormone Replacement Therapy | |
| E-sure | | Use any other form of Birth Control | | Are you Pregnant or Planning to be Pregnant (next 6 months) | |
| PCOS | | Full Hysterectomy | | Partial Hysterectomy | |

Do you still menstruate regularly? _____ Yes _____ No
 If No, When did you Stop Menstruating and Why? _____

Primary Care Physician:

Full Name: _____
 Address: _____
 Phone Number: _____

Additional Care Provider(s)

Full Name: _____
 Address: _____
 Phone Number: _____

Consent to Contact PCP or Other Health Care Providers:

 Sign

 Date