ACUPUNCTURE
WELLNESS CENTER LLC
EAT WELL - LIVE WELL - BE WELL

3712 MacArthur Blvd. Ste 208. New Orleans, LA 70114
Tel. 504-362-8020
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www.nolaacupuncture.com

FOR STAFF: PATIENT SHOULD COMPLETE NEW PATIENT INTAKE FORM

Weight Control Program Registration

Your questionnaire provides valuable information which helps us understand the underlying causes of your health concerns. All questions contained in this history form are strictly confidential and will become part of your medical record on file.

PATIENT NAME: _____ Date: _____

WEIGHT HISTORY

1. What was your highest adult weight and when? _____
2. What was your lowest adult weight and when? _____
3. Indicate your childhood weight status: ❑ Under ❑ Average ❑ Over
4. What do you think is the main cause of your weight problems? _____

_____

_____

5. Which statement(s) best describes why you think you are overweight?
   - ❑ I eat normal amounts of foods but have an abnormal metabolism.
   - ❑ I eat larger than normal amounts of healthy foods.
   - ❑ I eat larger than normal amounts of healthy foods as well as sweets and snacks.
   - ❑ I tend to eat a good amount of sweets and high calorie snacks.
   - ❑ I am a compulsive eater.
   - ❑ Other: _____

6. Historically, have you ever used any of the following to control your weight?
   - ❑ Binge eating and purging ❑ Binge eating followed by restriction ❑ Vomiting ❑ Laxatives
   - ❑ Diuretics ❑ Nonprescription medications or over-the-counter weight loss pills
   - ❑ Prescription medications (i.e. Phen-fen, meridia, orlistat…)
   - ❑ Other: _____

7. Please indicate the following methods of weight loss you have attempted and comment on your experience with it. You may indicate pounds lost and length of time on program

Commercial Diets	**Comments**
❑ Weight Watchers	_____
❑ Jenny Craig	_____
❑ Overeaters Anon	_____
❑ TOPS	_____
❑ Nutrisystem	_____
❑ Other: _____	_____

Prescription Meds	**Comments**

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❑ Redux (dexfenfluramine) _____
❑ Pondimin (fenfluramine) _____
❑ Fen/Phen _____
❑ Phentermine/Fastin/Adipex _____
❑ Meridia _____
❑ Xenical/Alli _____
❑ Other: _____ _____

Liquid Diets **Comments**
❑ Optifast _____
❑ HMR _____
❑ Slimfast _____
❑ Other: _____ _____

Popular **Comments**
❑ Atkins _____
❑ Pritikin _____
❑ Southbeach _____
❑ Mac Dougal _____
❑ Self Initiated _____

Medical and Health Care Treatments **Comments**
❑ Previous Gastric Surgery _____
❑ Jaw Wiring _____
❑ Other Surgery: _____ _____
❑ Hypnosis _____
❑ Acupuncture _____
❑ Other: _____ _____

NUTRITION HISTORY

1. How many times a day do you eat? ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

2. Indicate which meals/snacks you typically eat: ❑ Breakfast ❑ AM snack ❑ Lunch ❑PM snack ❑Dinner ❑Evening snack
Please list the foods you currently eat the most

For Breakfast: _____ For Lunch: _____

_____ _____

_____ _____

For Dinner: _____ For Snacks: _____

_____ _____

_____ _____

3. How many **meals per week** do you eat the following:
Fast foods: _____ Takeaways: _____ Cafeteria: _____ Sit down restaurants: _____ Frozen meals: _____

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4. Who prepares your meals? _____ Who does the shopping? _____

5. Do you feel as if you frequently need to "eat on-the-run"? ❑ Yes ❑ No

6. Which of the following fats do you use regularly?
❑ Butter ❑ Margarine ❑ Salad dressing ❑ Oil ❑ Mayonnaise ❑ Cream cheese

7. How often do you eat some sort of fried food such as French fries, fried chicken, fried fish, tempura, potato chips or tortilla chips?
_____ / day or _____ / week

8. Which of the following beverages do you drink and how much?:
Coffee: ❑ regular ❑ decaf ❑ latte How much? _____ / day or _____ / week
Tea: ❑ regular ❑ decaf ❑ Chai How much? _____ / day or _____ / week
Juice: ❑ natural ❑ fruit drinks How much? _____ / day or _____ / week
Soda: ❑ regular ❑ diet How much? _____ / day or _____ / week
Smoothies: How much? _____ / day or _____ / week
Milk: ❑ whole ❑ 2% ❑ 1% ❑ skim How much? _____ / day or _____ / week
Water: ❑ tap ❑ bottled still ❑ carbonated How much? _____ / day or _____ / week
Alcohol: ❑ wine ❑ beer ❑ mixed drinks How much? _____ / day or _____ / week

9. How often do you eat red meat? _____ / day or _____ / week

10. How often do you eat poultry? _____ / day or _____ / week

11. How often do you eat fish? _____ / day or _____ / week

12. How often do you eat sweets (cookies, cakes, candy, ice cream, chocolate)? _____ / day or _____ / week

13. Do you feel you crave any of the following foods?
❑ Rice ❑ Pasta ❑ Bread ❑ Cereal ❑ Potatoes ❑ Other: _____

14. How often do you eat fruit? _____ / day or _____ / week

15. How often do you eat vegetables? _____ / day or _____ / week

16. Do you drink milk or eat cheese or yogurt every day? ❑ Yes ❑ No

17. Do you get up at night to eat? ❑ Yes ❑ No If yes, what do you eat when you get up? _____

18. Do you consume more than half of your daily calories after 7 pm? ❑ Yes ❑ No

19. Does it take you longer than 10 minutes to eat a meal? ❑ Yes ❑ No

20. What do you perceive as the biggest weakness in your diet? _____
_____
_____

21. What are your favorite foods? _____
_____
_____

22. What foods do you avoid and why? _____
_____
_____

23. If you use eating as an emotional outlet, what will you substitute when your eating is restricted? _____
_____
_____

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EXERCISE HISTORY

1. How physically active are you? ❑ Very Active ❑ Active ❑ Average ❑ Inactive ❑ Very Inactive ❑ Other:_____

2. What do you do for physical activity and how often do you do it?

Activity	Number of Times/Week	How Long
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. How long have you been engaged in your current regimen? _____

4. Is there anything that prevents you from being physically active? _____

5. How committed are you to incorporating daily physical activity into your lifestyle?
Rate from 1(not committed) to 10 (it will happen without a doubt): _____

Support System

1. What are the attitudes of the following people about your attempt(s) to lose weight?

Spouse:	❑ Negative	❑ Indifferent	❑ Positive	❑Other: _____
Children:	❑ Negative	❑ Indifferent	❑ Positive	❑Other: _____
Parents:	❑ Negative	❑ Indifferent	❑ Positive	❑Other: _____
Employer:	❑ Negative	❑ Indifferent	❑ Positive	❑Other: _____
Friends:	❑ Negative	❑ Indifferent	❑ Positive	❑Other: _____

2. Do these attitudes affect your weight loss or gain? ❑ Yes ❑ No If yes, please describe:_____

3. Is there somebody to assist you with activities of daily living post operatively? _____