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Center for Lifestyle Medicine Initial Assessment

259 East Erie Street, Suite 1600 | 312.695.2300 | 312.926.6068 (fax)

Name: _____ Date: _____

BACKGROUND QUESTIONS

Preferred phone: _____ E-mail: _____

Occupation: _____ Work hours: _____

Marital Status (please check): ◯ Single ◯ Married ◯ Divorced ◯ Widow ◯ Partnered

Please list names of the people in your household and their relationship to you:

_____ _____

_____ _____

Do you own a family dog? ◯ Yes ◯ No

What is the highest level of education completed? _____

What prompted you to seek services at this time? _____

What are your personal goals we can help you achieve? _____

OVERALL HEALTH QUESTIONS

Primary care provider: _____ Phone: _____

Address: _____

When was your last physical exam? _____ When did you last have blood tests? _____

How would you rate your health? (please check): ◯ Excellent ◯ Good ◯ Fair ◯ Poor

Height: _____ Weight: _____

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Center for Lifestyle Medicine Initial Assessment (continued)

PAST MEDICAL HISTORY Mark (x) all that apply:

- ◯ Acid Reflux (GERD)
- ◯ Anemia
- ◯ Anorexia
- ◯ Anxiety
- ◯ Arthritis
- ◯ Asthma/Lung Problem
- ◯ Attention Deficit Disorder
- ◯ Bipolar Disorder
- ◯ Bleeding Disorders
- ◯ Blood clot/DVT
- ◯ Bulimia
- ◯ Cancer
- ◯ Celiac Disease
- ◯ Congestive Heart Failure
- ◯ Drug/Alcohol Dependency
- ◯ Depression
- ◯ Diabetes (Type 1)
- ◯ Diabetes (Type 2)
- ◯ Emphysema/Chronic Bronchitis
- ◯ Epilepsy/Seizure Disorder
- ◯ Fatty Liver Disease
- ◯ Gallbladder Disease/Stones
- ◯ Glaucoma
- ◯ Gout
- ◯ Heart Disease/Heart Attack
- ◯ Heart Murmur
- ◯ Hepatitis
- ◯ High Blood Pressure/ Hypertension
- ◯ High Cholesterol
- ◯ HIV Disease
- ◯ Irregular Menstrual Periods
- ◯ Impaired Fasting Glucose/ Pre-Diabetes
- ◯ Kidney Disease
- ◯ Liver Disease
- ◯ Migraines
- ◯ Multiple Sclerosis
- ◯ Obsessive Compulsive Disorder
- ◯ Osteoporosis/penia
- ◯ Polycystic Ovarian Syndrome (PCOS)
- ◯ Pacemaker
- ◯ Prostate Problem
- ◯ Sickle Cell Disease
- ◯ Sleep Apnea
- ◯ Stroke
- ◯ Thyroid Disease
- ◯ Tuberculosis
- ◯ Ulcer Disease
- ◯ Other

REVIEW OF SYSTEMS Mark (x) all that apply:

GENERAL	◯ Fever/chills ◯ Fatigue	◯ Weakness ◯ Low energy level
RESPIRATORY	◯ Excessive shortness of breath ◯ Coughing ◯ Wheezing	◯ Snoring ◯ Daytime sleepiness ◯ Disturbed sleep
CARDIAC	◯ Chest pain ◯ Irregular heart beat ◯ Palpitations	◯ Ankle or feet swelling ◯ Varicose veins
GASTROINTESTINAL	◯ Indigestion/heartburn ◯ Nausea/vomiting ◯ Abdominal pain ◯ Hemorrhoids	◯ Diarrhea ◯ Constipation ◯ Change in bowel habits ◯ Rectal bleeding
GENITOURINARY	◯ Difficulty urinating ◯ Urinary incontinence ◯ Inability to empty bladder fully ◯ Abnormal menstrual period	◯ Recurrent urinary infections ◯ Infertility ◯ Sexual problems ◯ Frequent urination

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Center for Lifestyle Medicine Initial Assessment (continued)

REVIEW OF SYSTEMS (continued) Mark (x) all that apply:

MUSCULOSKELETAL	◯ Back pain ◯ Joint pain ◯ Difficulty walking	◯ Muscle cramps ◯ Muscle weakness
ENDOCRINE	◯ Excessive thirst ◯ Excessive/increased urination	◯ Cold/heat intolerance ◯ Blurry vision
NEUROLOGIC	◯ Headaches ◯ Seizures ◯ Tremors	◯ Dizziness ◯ Numbness ◯ Tingling
SKIN	◯ Infection (boils, ulcers, etc) ◯ Chronic rashes ◯ Acne	◯ Abnormal bruising ◯ Excessive hair growth (females) ◯ Changes in skin color
PSYCHOLOGICAL	◯ Lack of interest in doing things ◯ Feel down, depressed or hopeless	◯ Anxious ◯ History of physical violence/abuse

Average hours of sleep each night _____ Is sleep refreshing? ◯ Yes ◯ No

How would you rate your stress level? **low** ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 **high**

How do you cope with daily stressors? _____

Are you currently seeing a mental health professional? ◯ Yes ◯ No

If yes, please provide name and contact information: _____

List all previous surgeries with date: _____

_____

List your current medications and dosages. Include any vitamins and supplements:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Do you have any allergies to medications? _____

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Center for Lifestyle Medicine Initial Assessment (continued)

Preventive care screenings and diagnostic tests you have had (please check and provide the date):

- ◯ Sigmoidoscopy/Colonoscopy_____
- ◯ Pap Smear _____
- ◯ Cardiac Stress Test _____
- ◯ Mammogram _____
- ◯ Bone Density _____
- ◯ Prostate/Testicular Exam _____

Tobacco history (please check): ◯ Never Smoked ◯ Past Smoker ◯ Current Smoker

Alcohol history (please check): ◯ Do Not Drink ◯ Currently Drink _____ drinks per week

Recreational drug use (please check): ◯ Never ◯ Past User ◯ Present User

FAMILY HEALTH HISTORY:

RELATION	AGE	MEDICAL CONDITIONS	OVERWEIGHT OR OBESE?	AGE AT DEATH
Father				
Mother				
Siblings				
Spouse				
Children				

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Center for Lifestyle Medicine Initial Assessment (continued)

NUTRITION QUESTIONNAIRE

What one or two things would you like to change about your diet? _____

Do you read food labels? If yes, what do you look for? _____

How confident are you about the *amount* of current nutrition knowledge you have? **low** ◯1 ◯2 ◯3 ◯4 ◯5 **high**

How confident are you about your ability to *apply* the nutrition knowledge you have? **low** ◯1 ◯2 ◯3 ◯4 ◯5 **high**

Do you have any food allergies? _____

Do you follow any special diet or dietary restrictions? _____

When and what do you usually eat over the course of a typical day? (Please list in table below):

MEAL	TIME	FOODS EATEN
Breakfast	_____	_____
Snack	_____	_____
Lunch	_____	_____
Snack	_____	_____
Dinner	_____	_____
Snack	_____	_____

What do you drink throughout the day? _____

How many meals per week do you eat in restaurants/order takeout? _____

Do you eat much more rapidly than others? ◯ Yes ◯ No

Do you eat until feeling uncomfortably full? ◯ Yes ◯ No

Do you eat large amounts of food when you are not feeling physically hungry? ◯ Yes ◯ No

Do you feel disgusted with oneself, depressed, or very guilty after overeating? ◯ Yes ◯ No

Do you eat alone because of being embarrassed by how much you are eating? ◯ Yes ◯ No

Do you have a history of an eating disorder? (If yes, please check):

◯ Compulsive Overeating ◯ Binge Eating Disorder ◯ Anorexia ◯ Bulimia

Do you feel that you have a food addiction (loss of control over food intake)? ◯ Yes ◯ No

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Center for Lifestyle Medicine Initial Assessment (continued)

PHYSICAL ACTIVITY QUESTIONNAIRE

What is the most active thing you do in an average day? _____

What, if any, regular exercise do you participate in and how often? _____

In general, how much do you enjoy doing physical activity? _____

low enjoyment ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 **high enjoyment**

What makes it difficult for you to exercise? _____

Do you know any other reason why you should not do physical activity? ◯ Yes ◯ No

When you exercise or exert yourself, do you have any of the following? (please check if yes)

◯ Shortness of breath ◯ Chest pain or pressure ◯ Pain in your calves

WEIGHT HISTORY

What was your lowest body weight as an adult? _____ lbs. At what age? _____

What was your highest body weight as an adult? _____ lbs. At what age? _____

Have you previously participated in a commercial or professional weight loss program? ◯ Yes ◯ No

(If yes, please check all programs):

◯ Weight Watchers ◯ Jenny Craig ◯ NutriSystem ◯ Women's Workout World ◯ Very Low Calorie Diet

◯ Weight Loss Medication _____ (name of medication) ◯ Other _____

Have you previously seen a Registered Dietitian (RD)? ◯ Yes ◯ No

Have you ever had weight loss surgery? If so, which one and when? _____

What is the maximum amount of weight you've lost in the past? _____ lbs.

What are the biggest challenges you face in losing weight/maintaining weight loss? _____

_____

How important is it for you to make lifestyle changes?

very important ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 **not important**

How confident are you in your ability to make lifestyle changes?

very confident ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 **not confident**

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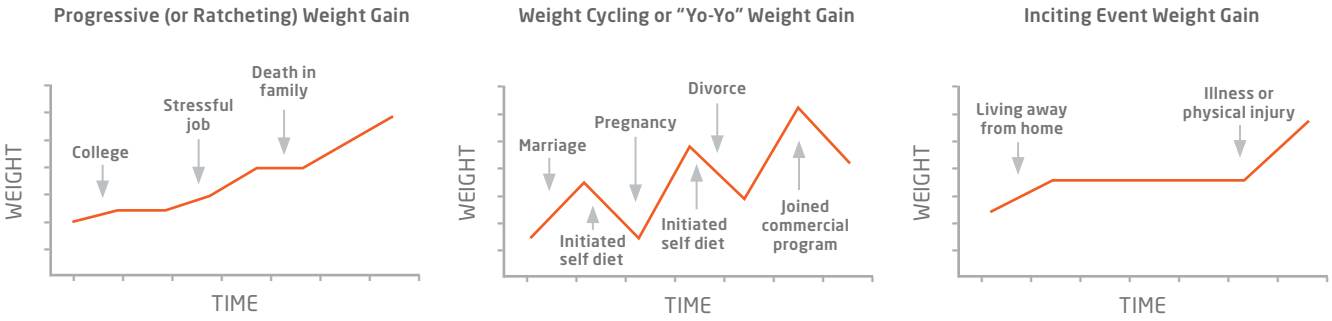
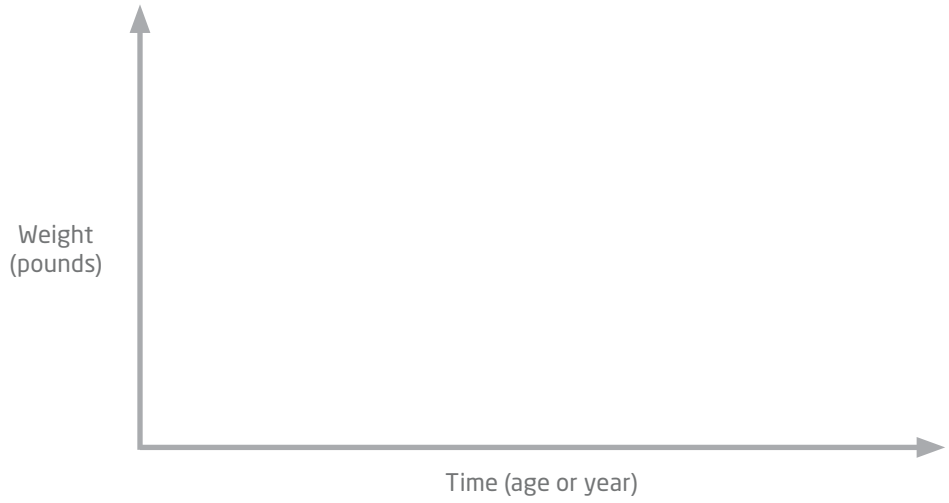
Center for Lifestyle Medicine Initial Assessment (continued)

Graphing your weight gain

Below are examples of typical weight gain patterns according to life events.



Using the examples as a reference, please graph your weight gain. Mark life events and diet attempts that may have contributed to your current weight.



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Center for Lifestyle Medicine Initial Assessment (continued)

SIX-FACTOR TRAIT QUESTIONNAIRE (6-FTQ) Please check your level of agreement to all statements:

	Don't agree at all	Agree a little	Agree	Strongly agree
CONVENIENT DINER				
1. I rarely take the time to plan my meals.	◯ 0	◯ 1	◯ 2	◯ 3
2. A lot of my meals are eaten in restaurants or taken out.	◯ 0	◯ 1	◯ 2	◯ 3
3. Most foods I eat are convenient, ready- made, packaged, frozen or microwavable.	◯ 0	◯ 1	◯ 2	◯ 3
4. I eat a fast-food meal on most days of the week.	◯ 0	◯ 1	◯ 2	◯ 3
5. I do not have consistent meal patterns from one day to the next.	◯ 0	◯ 1	◯ 2	◯ 3
Sub score				
FAST PACER				
6. My fast-paced life leaves me feeling drained and scattered.	◯ 0	◯ 1	◯ 2	◯ 3
7. I feel like I'm juggling too many things at once.	◯ 0	◯ 1	◯ 2	◯ 3
8. I usually take care of everyone else and put myself at the bottom of my to-do list.	◯ 0	◯ 1	◯ 2	◯ 3
9. My hectic schedule makes it hard for me to focus on my health.	◯ 0	◯ 1	◯ 2	◯ 3
Sub score				
EASILY ENTICED EATER				
10. I have difficulty controlling my portion sizes.	◯ 0	◯ 1	◯ 2	◯ 3
11. I often eat out of habit, not because I am hungry.	◯ 0	◯ 1	◯ 2	◯ 3
12. When I'm stressed, lonely, anxious or depressed, I turn to food for comfort.	◯ 0	◯ 1	◯ 2	◯ 3
13. If there is food around me, I'll probably eat it.	◯ 0	◯ 1	◯ 2	◯ 3
14. I snack throughout the day, hungry or not.	◯ 0	◯ 1	◯ 2	◯ 3
15. I will eat until I'm too full – and may even eat more.	◯ 0	◯ 1	◯ 2	◯ 3
Sub score				

Continued >

Center for Lifestyle Medicine Initial Assessment (continued)

SIX-FACTOR TRAIT QUESTIONNAIRE (6-FTQ) Please check your level of agreement to all statements:

	Don't agree at all	Agree a little	Agree	Strongly agree
EXERCISE STRUGGLER				
16. Of all things being physically active has never been one of my priorities.	◯ 0	◯ 1	◯ 2	◯ 3
17. I don't exercise because frankly I don't like it.	◯ 0	◯ 1	◯ 2	◯ 3
18. I never got "into" exercising because I am not sure where to start.	◯ 0	◯ 1	◯ 2	◯ 3
19. I have difficulty exercising.	◯ 0	◯ 1	◯ 2	◯ 3
	Sub score			
SELF-CRITIC				
20. I measure my self-worth by the numbers on the bathroom scale.	◯ 0	◯ 1	◯ 2	◯ 3
21. I focus on the things I don't like about my body.	◯ 0	◯ 1	◯ 2	◯ 3
22. I make a habit of saying bad things about myself.	◯ 0	◯ 1	◯ 2	◯ 3
23. I avoid social situations because of my weight.	◯ 0	◯ 1	◯ 2	◯ 3
	Sub score			
ALL-OR-NOTHING DOER				
24. I approach my weight loss like it's just another project with a clear beginning and end.	◯ 0	◯ 1	◯ 2	◯ 3
25. I'm either on or off my diet – there's no middle ground with me.	◯ 0	◯ 1	◯ 2	◯ 3
26. When I'm trying to lose weight, I give 100% of my effort but this is hard to sustain.	◯ 0	◯ 1	◯ 2	◯ 3
27. I am all or nothing when it comes to dieting or exercising to lose weight.	◯ 0	◯ 1	◯ 2	◯ 3
	Sub score			

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