Center for Metabolic Health and Weight Management

Metabolic Health and Weight Management Program Intake Form

In order for us to process your enrollment form quickly and accurately, please print legibly and be sure to complete the entire form. Please bring this form to the clinic, e-mail it to WBHMetabolicHealth@hfhs.org or fax the form to (248) 325-3187 prior to your first appointment. If you are unsure of what to do, please contact a staff member for assistance at 248-325-1355.

Mr. Ms. Mrs. (circle one) First Name: _____ MI: _____ Last Name: _____

I identify my gender as: _____ DOB: ____/____/_____

E-Mail Address: _____ Address:_____

City: _____ State (Province): _____Zip (Postal Code): _____

Home Phone: (_____)_____ Other Phone: (_____)_____

If you are a Henry Ford patient, do you use MyChart? (circle one) Yes | No | I don't know

Marital Status (circle one): single | married | widowed | divorced Occupation: _____

Indicate what types of medication you are currently taking (prescription and over the counter - choose all that apply):

- ☐ NONE
- ☐ for Weight Loss
- ☐ for High Blood Pressure
- ☐ for Heart Disease
- ☐ for Birth Control
- ☐ for Hormone Replacement
- ☐ for Diabetes
- ☐ for Depression
- ☐ for Anxiety
- ☐ for Sleep
- ☐ for Hypothyroidism
- ☐ for Gout
- ☐ for Allergies
- ☐ OTHER

Please list any current intake of vitamins, minerals and/or herbal supplements (including frequencies and dosages):

List ALL medication you are currently taking below (prescription and over the counter – include the name of the medication, dosage, and frequency for each medicine):

List any medication allergies:

List any food allergies or intolerances:

What is your experience with smoking tobacco? (choose one):
☐ Never smoked ☐ Quit smoking ☐ Less than pack/day ☐ Up to 2 packs/day ☐ More than 2 packs/day
If you smoke or used to smoke, How long? _____ yrs If you quit smoking, when? (date)_____

Do you use alcohol? (choose one):

☐ Never ☐ Quit drinking ☐ Less than 3 drinks/week ☐ Up to 14 drinks/week ☐ More than 14 drinks/week

Do you use other recreational substances? ☐ Yes ☐ No ☐ Prefer not to Answer

What types of physical activities do you enjoy?

How often do you participate in these activities?

What exercises do you do regularly?

Do you belong to a health club or attend classes? ☐ Yes ☐ No

How often do you attend?	Less than once per week 1-2 times per week 3-5 times per week 6 or more times per week

How many hours of television do you watch every day?		How many hours are you at a computer/desk every day?	

What types of exercise equipment or exercise tapes do you have at home?

Would you like to change your physical activity/exercise habits? ☐ Yes ☐ No

Which physical activity habits would you like to begin to change?

Do you experience any barriers to being physically active such as pain or discomfort, time etc.? ☐ Yes ☐ No

If yes, please describe: _____

What is the reason you are seeking treatment at this time?

What are your goals about lifestyle change?

Your level of interest in changing your lifestyle is:

Not interested 1 2 3 4 5 Very Interested

How much support can your family provide?

No support 1 2 3 4 5 Much support

How much support can your friends provide?

No support 1 2 3 4 5 Much support

What is the hardest part about lifestyle change?

What do you believe will be of most help to assist you in lifestyle changes?

How confident are you that you can change your lifestyle at this time?

Not confident 1 2 3 4 5 Very confident

What has been your lowest body weight as an adult?	Your heaviest weight as an adult?	At what age did you start trying to lose weight?

Please list the factors you feel have contributed to your current weight (check all that apply):

☐ Weight gain following an injury	☐ Lack of exercise
☐ Pregnancy	☐ Binge eating
☐ Poor food choices	☐ Late night snacking
☐ Stress-related eating	☐ History of trauma
☐ Slow metabolism	☐ History of grief and loss
☐ Family history of obesity	☐ Medication-related weight gain
☐ Comfort food dependency	☐ Significant restrictive eating behaviors (ex. anorexia)

☐ Purging behaviors including laxatives, self-induced vomiting or over exercising

☐ Other (please list):

Weight Loss Therapies	Timeframe	Please describe your experience with this therapy
Medications: Meridia, Alli, Phentermine, Adipex, Dexatrim, Metabolife, Acutrim, Qsymia, Belviq, Contrave, Saxenda, Prozac, Metformin Other:		
Nutritional supplements such as B12 Shots, HCG Shots or Diuretics		
Low Carb Diet: South Beach, Atkins		
Physician-Supervised Diet Plan		
Weight Watchers		
High Protein-Liquid Diet or Meal Replacement Programs: Medical Weight Loss, Opti-Fast, Medi-Fast, LA Weight Loss, HMR, Jenny Craig, Nutri-System		
Registered Dietitian Counseling or other Counseling or Therapy		
Gyms, Exercise Programs or Fitness Clubs		
Acupuncture or Hypnosis		
Other:		
If you regained weight, what do you think was the primary reason?		

How many pieces of fruit do you eat daily?	
How many fresh or cooked veggies do you eat daily?	
How many times do you eat legumes (ex. beans, peas and lentils) per week?	
How many meals away from home per week?	
When you do not eat at home, where do you usually eat?	
Who does the food shopping for the meals you eat at home?	
Who prepares the meals you eat at home?	
Do you usually stop eating when you are full?	☐ Yes ☐ No
Are you lactose intolerant?	☐ Yes ☐ No
Meal replacements can include shakes, bars and pre-packaged food items. Are you interested in using meal replacements to help you eat healthier?	☐ Yes ☐ No ☐ I don't know

How frequently do you (please circle one):		
Never = Less than 1x/month	*Sometimes = 1x/month to 1x/week*	*Often = 2x/week or more*
Skip breakfast (ie. Not eat within one hour of awakening)?		Never Sometimes Often
At any point during the day, go more than 3 hours without eating anything?		Never Sometimes Often
Eat high-calorie foods within one hour of going to bed?		Never Sometimes Often
Awaken to eat in the middle of the night?		Never Sometimes Often
Eat in isolation due to embarrassment that what, or how, you are eating may be criticized by others?		Never Sometimes Often
How often do you do something else while you're eating (mindless eating)?		Never Sometimes Often
Eat fast foods (venue that has a drive thru or prepares the food in under 5 minutes)?		Never Sometimes Often
Eat at a sit-down restaurant (including carry out from a sit-down restaurant)?		Never Sometimes Often
Eat deep-fried foods (fries, chips, fish, chicken, calamari, falafel, etc.) or add oil to foods/meals?		Never Sometimes Often
Eat cheese (separately or on a salad, pizza, sandwich, cracker, etc.) or other full/low-fat dairy such as butter, whole or low-fat milk, sour cream, and cream cheese?		Never Sometimes Often
Eat large amounts of food, beyond satisfying hunger, to the point of discomfort, guilt and with feelings of being out of control?		Never Sometimes Often
Eat red meats including steak, burgers, ground meat, red meat cold cuts, red meat hot dogs?		Never Sometimes Often
Eat high-salt meats including ham, corned beef, deli turkey, deli chicken, deli roast beef, sausage or bacon?		Never Sometimes Often
Eat high-calorie foods such as bread, bagels, dry cereals, crackers, corn or potato chips, pretzels, popcorn, tortillas, flour-based wraps or dried fruits (note: these are commonly high in sodium as well)?		Never Sometimes Often
Eat dessert-type foods such as pastries, doughnuts, pies, cakes or chocolates		Never Sometimes Often
Eat medium-calorie starches, grains and starchy veggies such as wheat (pasta, bulger, cream of wheat etc.), rice, corn, oatmeal, quinoa, farrow, potatoes or barley etc.?		Never Sometimes Often
Eat nuts and seeds (note: though high in calories, these can be very healthy when portioned)?		Never Sometimes Often
Drink thin liquid calories such as sugar (including high-fructose corn syrup), sweetened pop, flavored drinks or juice drinks, fruit juice, alcohol, coffee creamers, sports drinks (ex. Gatorade)?		Never Sometimes Often

Please describe what your food intake looks like on a typical day		
Meal	**Time/Place**	**What would you eat and drink? (please include amounts)**
Breakfast/1st Meal		
Snack		
Lunch/2nd Meal		
Snack		
Dinner/3rd Meal		
Snack		
Other		