Laser Skin & Wellness

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Nutritional & Wellness Intake Form

Name_____ **Date**_____

Address: _____

City: _____ State: _____ Zip: _____

Phone number to contact you / leave a message: _____
Is this your: Cell / Work / Home

Email: _____

How did you hear about us: _____

Birthdate _____/_____/_____ Gender M_____ F_____

Occupation: _____

Primary Care Physician _____Phone Number _____

Pharmacy _____Phone Number _____

1. Present Weight:_____ Height:_____ Desired Weight_____

2. In what time frame would you like to be at your desired weight?_____

3. What is the main reason for your decision to lose weight?_____

4. When did you begin gaining excess weight?_____

5. What has been your maximum weight (non-pregnant) & when? _____

_____

6. Previous diets you have followed: Dates and results of diet:

_____ _____

_____ _____

7. Is your Spouse ❑ Mom ❑ Dad ❑ Sibling ❑ Overweight?

8. How often do you eat out?_____

9. How often do you eat "fast food"?_____

10. Who plans meals? _____ Cooks? _____ Shops? _____

11. What food do you crave? _____

12. Any specific time of the day or month do you crave food?_____

13. Do you drink coffee ❑ tea ❑ soda ❑? How much daily?_____

14. Do you drink alcohol? Yes ❑ No ❑ What? _____Weekly? _____

15. Do you awaken hungry during the night? Yes ❑ No ❑ What do you do?

_____

16. What are your worst eating habits? _____

17. Snack habits: What?_____How much?_____When?_____

18. Are you an emotional eater? _____

19. Describe you energy level? _____

20. Behavior style: (answer only one)
___ You are always calm and easygoing
___ You are usually calm and easygoing
___ You are sometimes calm with frequent impatience
___ You are seldom calm and persistently driving for advancement
___ You are never calm and have overwhelming ambition
___ You are hard-driving and can never relax

21. Please check any mental health problems, current or past:

❑ Anxiety	❑ Drug Addiction	❑ Bulimia
❑ Alcoholism	❑ Bing Eating	❑ Panic Attacks
❑ Anorexia	❑ Suicidal Plans	❑ Nervous Breakdown
❑ Suicidal Thoughts	❑ Bipolar Disorder	
❑ Depressions	❑ Schizophrenia	

22 Are you in good health at the present time? _____

23. Please describe you general health goals and improvements you wish to make:

FOR WOMEN:

First Period_____ Pregnancies: Number_____ Natural Delivery or C-Section_____ Last Period_____

❑ ❑ Are you pregnant or trying to become pregnant? Last Check up_____

❑ ❑ Do you use oral contraceptives? Type_____

❑ ❑ Do you use hormone replacement therapy? Type_____

Do you have any of the following skin disorders?

❑ Psoriasis ❑ Dermatitis ❑ Eczema ❑ Keloid Scarring
❑ Fever Blisters ❑ Cold Sores ❑ Sun Blisters ❑ Herpes Simplex/Blisters
❑ Other: _____

Past Medical History:

[ ] High blood pressure
[ ] Heart disease
[ ] Diabetes
[ ] Hepatitis
[ ] Anemia
[ ] Leg or [ ] Lung blood clots
[ ] Sickle cell
[ ] Blood transfusions
[ ] Stroke
[ ] Bladder infections
[ ] Skin fungus
[ ] Bone fractures
[ ] Breast cancer
[ ] Sleep problems
[ ] Seizures
[ ] Sexually transmitted diseases
[ ] Uterine fibroids
[ ] Abnormal PAP smears
[ ] PMS
[ ] Genital Herpes or blisters
[ ] Oral Herpes or blisters
[ ] Osteoporosis
[ ] Endometriosis
[ ] Pneumonia
[ ] Kidney problems
[ ] PCOS
[ ] Cystic Acne
[ ] Glaucoma
[ ] Liver Disease
[ ] Depression
[ ] Psychiatric problems
[ ] Thyroid disease
[ ] Irritable bowel
[ ] Stomach ulcers
[ ] Arthritis
[ ] Headaches
[ ] Asthma
[ ] Autoimmune (lupus, scleroderma)
[ ] Radiation treatment
[ ] Genital warts
[ ] Constipation
[ ] Skin cancer (type)_____ [ ] Other cancer(type)_____
[ ] Other_____

Past Surgeries_____

_____

Weight-Loss Consumer Bill of Rights

Warning: Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1 ½ pounds to 2 pounds per week or weight loss of more than 1 percent of body weight per week after the second week of participation in a weight-loss program. Consult your personal physician before starting any weight-loss program. Only permanent lifestyle changes, such as making healthful food choices and increasing physical activity, promote long-term weight loss. Qualifications of this provider are available upon request. You have a right to: ask questions about the potential health risks of the program and its nutritional content, psychological support and educational components; receive an itemized statement of the actual or estimated price of the weight-loss program, including extra products, services, supplements, examinations and laboratory tests; know the actual or estimated duration of the program; know the name address and qualifications of the dietitian or nutritionist who has reviewed and approved the weight-loss program according to s.468-050 (1)(j), Florida Statutes.

I have read the above: _____(patient signature)