AtLast Medical Weight Loss
MEDICAL ASSOCIATES OF THE SHOALS, P.C.

Patient Name:		**Date of Birth:**
Height:	**Current Weight:**	**Goal Weight:**

Lowest weight:	**When were you at your lowest weight?**
Highest weight:	**When were you at your highest weight?**

How long have you been trying to lose weight?

At what age did you begin to weigh more than you think you should weigh?

- ☐ Grade School
- ☐ High School
- ☐ Age 18-29
- ☐ Ages 30-39
- ☐ Ages 40-49
- ☐ Ages 50-59
- ☐ Ages 60+
- ☐ I have struggled with being overweight my entire life.

At what age did you start trying to lose weight?

What do you think is the cause of your being able to maintain a weight you would like?

Have you ever stayed the same weight for 10 years or more? ☐ Yes ☐ No

What is your motivation for wanting to lose weight? Check all that apply.

- ☐ Don't like the way I look
- ☐ More energy
- ☐ Better work opportunities
- ☐ Attend a wedding/graduation
- ☐ Attend a reunion
- ☐ Upcoming event or vacation
- ☐ Better mobility
- ☐ Feel more socially confident
- ☐ Clothes don't fit anymore
- ☐ Improve health
- ☐ Feel better
- ☐ Want to wear a smaller size
- ☐ Look more attractive for my partner
- ☐ Want to wear more stylish clothing
- ☐ Reduce medications
- ☐ Other (please describe):_____

What dietary habits or patterns apply to you? Check all that apply.

- ☐ Skipping meals
- ☐ Craving carbohydrates
- ☐ Large portion size
- ☐ Too much alcohol
- ☐ Frequent snacking
- ☐ Binging on food
- ☐ Eating foods too high in fat
- ☐ Eating too much fast food or too many meals in restaurants
- ☐ Eating for reasons other than hunger
- ☐ Eating before going to bed or getting up at night to eat
- ☐ Making yourself vomit after meals
- ☐ Drinking sugary sodas, sweet tea, or juices

How did you learn about the program?

- ☐ Patient Referral
- ☐ Printed Ad (Please identify):_____
- ☐ Internet
- ☐ Clinic website
- ☐ My Physician (Please identify):_____
- ☐ Passing by our Office
- ☐ Other (Please describe):_____

Patient Name:	Date of Birth:

What weight loss programs have you previously participated in?

Name of Program	Pounds Lost?	Length of Participation?
Weight Watchers		
Jenny Craig		
Slim Fast		
Atkins		
South Beach		
LA Weight Loss		
Nutri-System		
Overeaters Anonymous		
Diet Pill From Doctor or Other Health Care Provider (please specify)		
Over the Counter Diet Pills (please specify)		
Weight Loss Surgery (please specify)		
Other (please specify)		

Did you maintain any weight loss for up to one year on any of these programs? ☐ **Yes** ☐ **No**

If you answered yes, please specify which program._____

Please answer the following questions on a scale of 1 – 10 (1-LEAST, 10-MOST).

____ Your level of interest in losing weight is?

____ How confident are you that you can keep weight off this time?

____ How confident are you that you can lose weight this time?

____ How much support can your family provide?

____ How much support can your friends provide?

____ Are you ready for lifestyle changes to be a part of your weight control program?

____ How confident are you that you can make lifestyle changes?

Patient Name:	Date of Birth:

Current Activity Level:

Leisure, Non-Work Activity	Work Activity
____ Inactive: No regular physical activity.	____ Inactive: Desk job, sitting while working.
____ Light Activity – No organized physical activity, light house/yard work.	____ Light Activity – Sitting most of the time, brief walking frequently.
____ Moderate Activity – Occasionally involved in activities such as weekend swimming, hiking, jogging, tennis, golf, etc.	____ Moderate Activity – Non-sitting, activity most of the time.
____ Heavy Activity – Regular participation in running, cycling, swimming, or other active sport at least 3 times per week.	____ Heavy Activity – Consistent lifting, heavy construction, or stair climbing
____ Vigorous Activity – Participation in extensive physical exercise for a minimum of 60 minutes per session at least four times per week.	____ Vigorous Activity – Extensive physical exercise for a minimum of 60 minutes per session at least 4 times per week (Example: Guide for mountain climbing expedition).

Physical limitations preventing exercise:

☐ Hip pain
☐ Knee pain
☐ Ankle pain
☐ Foot pain
☐ Other (specify)_____

☐ Back pain
☐ Fatigue
☐ Excessive sweating
☐ Shortness of Breath
☐ Chest pain or discomfort

In the past year, have there been any changes in your family. Check all that apply.

☐ Marriage
☐ Separation
☐ Divorce

☐ Birth
☐ Loss of Job
☐ Serious Illness

☐ Death
☐ Other (please specify)_____

Please rate the intensity of any of these symptoms you have had in the past:

0 = No problem	1 = Minor Problem	2 = Big Problem
___ Hunger	___ Cravings	___ Mood Swings
___ Irritability	___ Headache	___ Feeling “wired”
___ Skin Rash	___ Diarrhea	___ Constipation
___ Hot Flashes	___ Dizziness	___ Dry Mouth
___ Blurred Vision	___ Excess Urination	___ Rapid Heart Rate
___ Palpitations	___ Insomnia	___ Anxiety
___ Shortness of Breath	___ Difficulty Urinating	___Excess Thirst