Jacksonville Children's and Multispecialty Clinic, P.A.

Wellness Clinic

Jacksonville Children's Clinic, Family Care Clinic, Swansboro Children's and Family Care, Jacksonville Children's and Family Care Clinic, Jacksonville Allergy, Asthma and Sinus, Jacksonville Urgent Care Jacksonville Gastroenterology, Jacksonville Behavioral and Mental Health, Sneads Ferry Pediatric and Family Care, and Richlands Children's and Family Care

118 Memorial Drive - Jacksonville, NC 28546 - (910) 353 0700 - fax (910) 353-1536

Intake Questionnaire

Name: Last: First MI

DOB:

Nutrition & Lifestyle Evaluation

1. **Main reason for losing weight:**
2. **Desired Weight:**
3. **Weight at 20 years age: _____Weight one year ago: _____**
4. **When did you begin gaining excess weight:**
5. **What was your maximum weight and when:**
6. **Is your spouse or partner overweight:**
7. **How often do you eat out every week:**
8. **How often do you eat fast food every week:**
9. **Food Allergies:**
10. **Foods you crave:**
11. **How much coffee or tea: _____cups/day**
12. **Previous Diet Regimens: Describe diet/name and Results**

    _____

13. **Do you consume alcohol: No Occasionally Weekly Daily**
    If yes, circle all that you drink: Beer Wine Other Spirits

14. **Smoking Habits: Never Quit _____years Smoker _____years**
    If yes, _____packs per day
15. **Activity level: chose one**
    a. **_____Inactive: No regular physical activity with a sit down job**
    b. **_____Light: No organized physical activity during leisure**
    c. **_____Moderate: Occasionally such as golf, tennis, jogging, cycling, swimming etc.**
16. **Briefly describe what weight control activity/exercise program you are currently on:**

_____

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Medical History

1. **Are you in good health at the present time**: _____Yes _____No :
   If no, explain_____
2. **Are you under a Doctor's care for a medical condition at present**: _____Yes _____No :
   If yes, explain_____
3. **List all Prescription drugs:**
   a. **Drug:** **Dosage:**
   b. **Drug:** **Dosage:**
   c. **Drug:** **Dosage:**
   d. **Drug:** **Dosage:**
   e. **Drug:** **Dosage:**
4. **List all "Over The Counter" medications:**
   a. **Drug:** **Dosage:**
   b. **Drug:** **Dosage:**
   c. **Drug:** **Dosage:**
   d. **Drug:** **Dosage:**
5. **Allergies to any Medications:** : _____Yes _____No :
   If yes, list_____
6. History of High BP: _____Yes _____No
7. History of Heart attack, Heart condition, Chest pain: _____Yes _____No
8. History of Glaucoma: _____Yes _____No
9. History of Bipolar disorder: _____Yes _____No

Past Medical History:

Anemia _____ Kidney disease _____ Heart disease _____ Sleep Apnea _____

Drug Abuse_____ Bleeding Disorder _____ Thyroid Disorder_____ Alcohol Abuse _____

Eating Disorder_____ Heart Valve disorder_____ Liver disease _____

Family History:

Heart disease/ Stroke: _____Yes_____No: Who _____ at what age: _____

Epilepsy: _____Yes _____No: Who _____

High Blood Pressure: _____Yes _____No: Who _____

Diabetes: _____Yes _____No: Who _____

Psychiatric disorder: _____Yes _____No: Who _____

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Review of Systems:

Chest pain: _____Yes _____No

Chest Pain with exercise: _____Yes _____No

Swelling of feet or hands: _____Yes _____No

Shortness of breath: _____Yes _____No

Snoring: _____Yes _____No

Back pain: _____Yes _____No

Hip pain: _____Yes _____No

Knee pain: _____Yes _____No

GERD: _____Yes _____No

Hernia: _____Yes _____No

Stretch Marks: _____Yes _____No

Varicose veins: _____Yes _____No

Cellulitis: _____Yes _____No

Intertrigo: _____Yes _____No

Skin tags: _____Yes _____No

Urinary Stress Incontinence: _____Yes _____No

Menstrual disorder: _____Yes _____No

Erectile dysfunction or decreased libido: _____Yes _____No