Prana Health
Ad Vitam - For Life

Prana Health Weight Management Clinic- ADULT

Please allow about 45minutes to complete the questionnaire. It is very important that everything is completed PRIOR to arriving for your first assessment.

Full Name _____ Height _____Weight _____ Weight 1 year ago_____

Lowest adult weight _____ What age? _____ How long? _____

Lowest adult weight maintained for 1 year _____ What age? _____

What is your personal goal weight at this time? _____ lbs.

Family History: List call close family members who are significantly overweight (20 lbs or more)

_____

_____

_____

Please record your major diets which resulted in a weight loss of 10 lbs. or more.

DIET	AGE	WEIGHT AT START OF DIET	POUNDS LOST	COMMENTS
1				
2				
3				
4				

How many times have you intentionally lost 20 lbs. or more and then gained it back?

Never ____ Once or twice ____ 3-4 times ____ 5 times or more ____

1) During the past 6 months, did you often eat within any two hour period what most people would regard as an unusually large amount of food? Yes _____ No _____

Morning (8 am to noon) _____ Early afternoon (noon to 4 pm) _____
Late afternoon (4-7 pm) _____ Evening (7-10 pm) _____ Night (after 10 pm) _____

e. Approximately how long did the episode last (from the time you started eating to when you stopped and didn't eat again for at least 2 hours)? _____ hours _____minutes

f. At the time the episode started, how long had it been since you had previously finished eating a meal or a snack? _____ hours _____minutes

Please list everything you might have eaten or drank during the episode. Include brand names where possible, and your best estimate of amounts

_____

_____

_____

Have you attempted any of the following behaviors in order to prevent gaining weight?

Behavior	Y	N	Number of times per week					
			<1	1	2-3	3-4	4-5	6-7
Taking more than twice the recommended dose of diet pills								
Taking more than twice the recommended dose of diuretics								
Taking more than twice the recommended dose of laxatives								
Vomiting after eating								
Abstaining for food for > 24 hours								
Exercising for > 1 hour								

Do you smoke cigarettes? Yes _____ No _____ If yes, # per day _____ # of years _____

Do you drink alcohol? Yes _____ No _____ If yes how much _____

Have you ever been the victim of abuse (physical, emotional, or sexual)? Yes _____ No _____

Marital or Relationship Status _____ Satisfaction with relationship right now _____

Occupation _____ What hours do you usually work? _____

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Have any of the following contributed to your weight problems?

	Y	N		Y	N
Stress			Restaurant eating		
Frustration			Sight and smell of food		
Boredom			Second helpings		
Happiness			Holidays		
Being with others			Snacking		

How many meals do you eat per day?_____

How often do you eat breakfast? _____ What? _____
_____

Do you eat before going to bed? _____ What? _____
_____

Do you eat while watching TV? _____ What do you eat? _____

How many times do you eat at:	2-3 times /day	1 times /day	2-3 times /week	1 time/ week	2-3 times /month
Fast Food Restaurants					
Vending Machines					
Hot Dog/ Food Stands					
Restaurants					
Other					

What is the most significant source of stress at this time? _____

Think back on other weight loss attempts. How are you most likely to sabotage your efforts, both short-term and long-term? _____

What are your current activities? (type, frequency, duration, length of consistency, level of enjoyment):_____

Days per week you are willing to devote to exercise_____

Is your typical work day mostly sedentary? Yes___No___

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Are you physically limited in any way? _____

PAST MEDICAL HISTORY

Medical illness: ☐Hypertension (high blood pressure) ☐Heart attack/Angina ☐Heart Failure ☐Head Injury ☐Diabetes ☐ Nasal Congestion/discharge/bleeding ☐ Nasal blockage ☐ Facial Pain/fullness/pressure ☐ Loss of sense of smell ☐Depression ☐Stroke ☐Arrhythmia ☐Atrial Fibrillation ☐COPD ☐Allergic rhinitis ☐Seizures ☐Iron Deficiency ☐Hypothyroidism ☐Acid reflux (GERD) ☐Dentures ☐Headache ☐TM joint pain ☐Erectile dysfunction

SURGICAL HISTORY:

☐Adeno-tonsillectomy ☐UPPP ☐Appendectomy ☐Gallbladder removal ☐Hysterectomy ☐Heart Bypass ☐Stent placement ☐Cataract surgery ☐Hernia repair ☐Knee replacement ☐Hip replacement ☐Pacemaker implantation ☐C-section ☐Knee surgery ☐Breast surgery ☐Back surgery ☐Sinus surgery

FAMILY HISTORY: Does anyone in your family have or has ever had any of the following (Please check all that apply): ☐Sleep apnea ☐Loud snoring ☐Restless Leg Syndrome (RLS) ☐Narcolepsy

☐Any other major illnesses in your parents or siblings that is not listed, (please describe):

_____

SOCIAL HISTORY

OCCUPATION:_____MARITAL STATUS:_____

Are you a current or former smoker? ☐No ☐Yes

Do you drink alcohol? ☐No ☐Yes If yes, how much?_____

Do you drink caffeinated beverages? ☐No ☐Yes If yes, how much?_____

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MEDICATION HISTORY

Have you ever been treated with sleeping medications in the past? If yes, please list them:

Drug	Dosage	Reason prescribed	Reason discontinued (Side effects or others)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any medication allergies: _____

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DEPRESSION SCREEN

1. **Over the *last 2 weeks,* how often have you been bothered by any of the following problems**

	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	0	1	2	3
b. Feeling down, depressed, or hopeless	0	1	2	3
c. Trouble falling/staying asleep, sleeping too much	0	1	2	3
d. Feeling tired or having little energy	0	1	2	3
e. Poor appetite or overeating	0	1	2	3
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
g. Trouble concentrating on things, such as reading the newspaper or watching tv.	0	1	2	3
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
i. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3
ADD COLUMNS:	_____ +	_____ +	_____ +	_____

TOTAL: _____

2. **If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

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Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the las 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the day	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	_____	_____	_____	_____

Total Score =_____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all_____

Somewhat difficult_____

Very difficult_____

Extremely difficult_____