

Prime Weight Loss  
 193 Terrill Road Suite A  
 Fanwood, NJ 07023

Today's Date: \_\_\_\_\_

Office Use ONLY		
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## Health Assessment

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone (Cell): \_\_\_\_\_ Phone (Home/Work): \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_

Email Address (Please Print) \_\_\_\_\_

Current Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Weight 1 Year Ago: \_\_\_\_\_

Lowest Adult Weight: \_\_\_\_\_ At what Age? \_\_\_\_\_ How long maintained? \_\_\_\_\_

Lowest Adult Weight Maintained for > 1 year \_\_\_\_\_ At what age? \_\_\_\_\_

What is your personal goal weight this time? \_\_\_\_\_ lbs

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

Never \_\_\_\_ Once or twice \_\_\_\_ 3-4 Times \_\_\_\_ 5+ Times \_\_\_\_

\*Have you ever been Diagnosed with an Eating Disorder? Yes or No If Yes, what type? \_\_\_\_\_

Do you exercise? Yes or No Frequency per week? \_\_\_\_\_ Hrs or mins per session \_\_\_\_\_

How long have you been exercising? \_\_\_\_\_ What type of exercise do you do? \_\_\_\_\_

### Check all that Apply:

<input type="checkbox"/> I eat when I am not hungry.	<input type="checkbox"/> I can over eat almost any food.
<input type="checkbox"/> I sometime eat much faster and/or much more than others.	<input type="checkbox"/> I graze or snack frequently between meals
<input type="checkbox"/> I isolate from others so I can eat the way I want.	<input type="checkbox"/> I am obsessive about the way I think about food.
<input type="checkbox"/> I sometimes think I will Eat moderately and then eat much more than I expected to eat.	<input type="checkbox"/> I think weight causes me serious physical and social problems and I still overeat
<input type="checkbox"/> I use food to numb difficult feelings	<input type="checkbox"/> I have tried to stop bingeing and been unable to stay stopped

### Medical Diagnosis: (Have you ever been Diagnosed with Anything?)

Year	Reason

List All Current Medications and Supplements Including Name, Frequency, and Dose (Include hormones and birth control pills.)

Name of Medication	Dose	Frequency	Name of Medication	Dose	Frequency

Do you Smoke Cigarettes? \_\_\_\_\_ (Y/N) If Yes, # per day \_\_\_\_\_ For how long? \_\_\_\_\_  
 Do you Drink Alcohol? \_\_\_\_\_ (Y/N) If yes, How Much/Quantity per Week? \_\_\_\_\_  
 Have you ever participated in Counseling or Psychotherapy? (Y/N) \_\_\_\_\_  
 If yes, Whom \_\_\_\_\_  
 Type: Individual: \_\_\_\_\_ Family \_\_\_\_\_ Couples \_\_\_\_\_ Substance abuse \_\_\_\_\_

**Check if YOU have or had any of the following:**

Condition	Check	Condition	Check	Condition	Check
Cancer (Active)		Asthma		Irregular Heartbeat	
Diabetes		Anemia		Phlebitis	
Kidney Disease (Dialysis) ESRD		Chest Pain		Low Back Pain	
Severe Depression		Chronic Diarrhea		Epilepsy	
Celiac		Chronic Constipation		Seizures	
Heart Disease		Fainting		Shortness of Breath	
Liver Disease		Frequent Headaches		Sleep Difficulties	
Kidney Disease (Non-Dialysis)		Frequent Nausea		Stroke	
		Gallbladder Disease		Swelling of Feet	
Cancer (Previously)		Gout		Thyroid Disease	
High Blood Pressure		Heartburn Allergies		Ulcers	
High Cholesterol		Dizziness		Yellowing	
Lap band		Arthritis		Hemorrhoids	
Gastric Bypass		Alcoholism/Drug Abuse		Neuropathy	
Anxiety/Panic Attacks		Mild Depression			

<b>For Women Only: Please check ALL that Currently Apply</b>			
Do you have an IUD		Do you take Birth Control	Hormone Replacement Therapy
E-sure		Use any other form of Birth Control	Are you Pregnant or Planning to be Pregnant (next 6 months)
PCOS		Full Hysterectomy	Partial Hysterectomy

Do you still menstruate regularly? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 If No, When did you Stop Menstruating and Why? \_\_\_\_\_

**Primary Care Physician:**

Full Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_

**Additional Care Provider(s)**

Full Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_

**Consent to Contact PCP or Other Health Care Providers:**

\_\_\_\_\_  
 Sign

\_\_\_\_\_  
 Date