SEMAGLUTIDE INTAKE FORM

Name:_____ Birth Date:_____

Address:_____

City:_____ State/Province:_____ Zip/Postal Code:_____

Phone #:_____ Emergency Contact:_____ Phone #:_____

Email:_____

Are you under a doctor's care at the present time? Yes No

If Yes, please list name of Dr. & Contact information:_____

_____

Do you currently have or have you had any of the following health conditions (Check all that apply):

- Alcohol Abuse
- Anemia
- Arthritis
- Asthma
- Bleeding Disorder
- Bloody Stool
- Bronchitis
- Cancer
- Chest Pain
- Constipation
- Convulsions
- Depression
- Diabetes
- Diarrhea
- Dizzy Spells
- Drug Abuse
- Eating Disorder
- Epilepsy
- Fainting Spells
- Fatigue
- Food Allergies
- Frequent Urination
- Gallbladder Disorder
- Glaucoma
- Gout
- Headaches
- Heart Disease
- High Cholesterol
- Hypertension
- Insomnia
- Irregular Pulse
- Kidney Disease
- Liver Disease
- Lung Disease
- Mental Illness
- Migraines
- Moodiness
- Nervousness
- Obesity
- Palpitations
- Rashes
- Shortness of Breath
- Sleep Apnea
- Stroke
- Thyroid Disease

Please list all surgeries & Other Hospitalizations:

Reason:_____ Year:_____ Hospital:_____

Reason:_____ Year:_____ Hospital:_____

Reason:_____ Year:_____ Hospital:_____

Reason:_____ Year:_____ Hospital:_____

Do you have any allergies? Yes No If Yes, please list all allergies:_____

_____

Are you currently taking any medications and/or supplements? Yes No If Yes, please list all medications and supplements you are taking:_____

_____

Do you have any allergies to medication? Yes No If Yes, please list medications:_____

_____

_____

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Please check next to the best one that describes your exercise habits:

- Inactive - No exercise activity with a sit down job
- Light Activity - No organized physical activity
- Moderate Activity - Occasionally involved in physical activity
- Heavy Activity -Heavy Construction, consisted lifting, stair climbing, or regular physical activities 3 x a week
- Vigorous Activity - Persistent physical exercise for at lease 60 minutes 4 x a week

Are you currently dieting now? Yes No

How many meals do you eat in an average day?_____

Is your daily salt intake: Low Moderate High

Is your daily caffeine intake: Low Moderate High How many cups/cans per day do you drink?_____

What types of caffeine do you drink? Coffee Tea Soda None

Do you drink alcohol? Yes No If Yes, how many per week?_____

Do you smoke? Yes No If Yes, do you smoke: Cigarettes Other Tobacco Products

If Yes to cigarettes, how many packs do you smoke per day?_____

*Women Only - Are you currently pregnant, trying to get pregnant, or currently breast feeding? Yes No

What is your main reason you want to lose weight? _____

_____

_____

At what age did you begin gaining excess weight (provide details if possible)? _____

_____

What is the main cause of your weight problems?_____

_____

_____

What other weight loss programs and previous diets have you tried?_____

_____

_____

_____

Do you have any food allergies or food you avoid?_____

_____

_____

What foods do you crave most often?_____

_____

_____

Please describe your snack habits:_____

_____

_____

Do you eat more when you are stressed? Yes No

What do you feel are your obstacle(s) to successful weight loss?_____

_____

_____

I certify that the preceding medical, medication, and personal history statements are true and correct. I am aware that it is my responsibility to inform the service provider or other health professional of my current medical health conditions and to update this history. A current medial history is essential for the service provider to execute appropriate treatment procedures. I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and I will not hold any staff member personally responsible for any errors or omissions that I have made in the completion of this form.

Client Name (Please Print):_____

Client Signature:_____ Date:_____