Holy City Med
Medically Managed Weight Loss Program Intake

Patient name: _____ Date of Birth: _____

1) What is your highest adult weight?_____
2) What is your lowest adult weight? _____
3) What was your situation during each of these events listed above? _____

   _____
4) What are your triggers for weight gain? _____
5) What is your motivation for weight loss? _____
6) What is your goal weight? _____
7) Have you made prior weight loss attempts or participated in other weight loss programs? If so, specify the program or medication and how much weight you lost.

   _____

   _____
8) What diet changes are you currently making? _____

   _____
9) What are you doing for exercise currently?_____

   _____
10) Do you have any barriers to exercise _____

    _____
11) How many hours do you sleep per night (average)? _____
12) What time do you typically wake and go to bed? _____
13) Describe what you eat for the following:
    a) Breakfast: _____
    b) Lunch:_____
    c) Dinner: _____

PATIENT NAME_____ DATE OF BIRTH_____

d) Snacks:_____

e) Beverages: _____

f) How much water intake? _____

14) What time do you eat your meals? _____

15) Do you ever eat with distractions? (TV, phone, games) _____

16) How often do you consume fast food? _____

17) Who prepares the meals in your household? _____

18) Are there any foods that you dislike? _____

19) Do you have any food allergies? _____

20) Do you have a history of any of the following medical conditions? Please circle

Hypertension // Hyperlipidemia // Sleep apnea // Type 2 Diabetes
PCOS // Low Testosterone

21) Have you had a wellness check up in the past 12 months with another primary care provider? YES // NO

22) How would you rate your stress level? (CIRCLE)
LOW // MODERATE // HIGH // SEVERE

23) Are you in any behavioral therapy or counseling currently? YES // NO

24) What do you do to relax? _____
_____

25) Are you pregnant or planning to become pregnant? YES // NO // Not Applicable

26) When was your last menstrual period? (if applicable) _____

27) Do you have a history of any of the following medical conditions?
PANCREATITIS // THYROID CANCER // THYROID TUMORS // TYPE 1 DIABETES
KIDNEY DISEASE // CARDIAC ISSUES // FAMILY HISTORY OF THYROID TUMORS

28) Are you currently taking any stimulant medications?_____

29) Are you currently taking any medications? _____
_____
_____
_____

PATIENT NAME_____ DATE OF BIRTH_____

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. 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
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

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? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**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 (add your column scores): _____

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? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

PATIENT NAME_____ DATE OF BIRTH_____

The Epworth Sleepiness Scale

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0, no chance of dozing, to 3, high chance of dozing. When you finish the test, add up the values of your responses. Your total score is based on a scale of 0 to 24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

How Sleepy Are You?
How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

- No chance of dozing =0
- Slight chance of dozing =1
- Moderate chance of dozing =2
- High chance of dozing =3

Write down the number corresponding to your choice in the right hand column. Total your score below.

Situation	Chance of Dozing
Sitting and reading	•
Watching TV	•
Sitting inactive in a public place (e.g., a theater or a meeting)	•
As a passenger in a car for an hour without a break	•
Lying down to rest in the afternoon when circumstances permit	•
Sitting and talking to someone	•
Sitting quietly after a lunch without alcohol	•
In a car, while stopped for a few minutes in traffic	•

Total Score = _____

Analyze Your Score

Interpretation:

0-7: It is unlikely that you are abnormally sleepy.
8-9: You have an average amount of daytime sleepiness.
10-15: You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.
16-24: You are excessively sleepy and should consider seeking medical attention.