Comprehensive Health Care inc.
CHC Medical Weight Loss Inc.

Health Risk Analysis

Today's Date: _____/_____/_____ DOB: _____/_____/_____ Age: ______ Height: ________ Weight: ________

Last Name______________________________________ **First Name**_________________________ Gender: **F** **M**

Address____City_____________________State______Zip____________

Email:____ Cell: (______)_________-___________

How did you hear about us?_________________________ If referred by someone, who?__________________________

Please answer the following questions honestly so we can do our best to help you reach your goals.

What made you decide to do something about your weight today? ____

____

Who encouraged you to lose weight?___________________________ Can you commit to one visit a week? **Y** **N**

What important reason, special occasion, or goal date do you have for wanting to lose weight?______________________

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How important to you is it that you lose weight?______________________________________

How many pounds would you like to lose?____________ How fast do you want to be slim, trim & fit?_________________

Have you ever attended any other weight reduction centers, if so, which ones?____________________________________

What kinds of diets have you tried on your own?____

What is the longest you have been able to stick with a diet?____

Does your family support your weight loss efforts? **Y** **N**

Have you been advised by your family physician to lose weight? **Y** **N**

If yes, what is your doctor's name? : ____

Do you eat because of emotions? **Y** **N** *If yes, please explain:* ____

____

____

On average, which of the following reflects your daily eating habits? **(Please check all that apply.)**

___ 3 meals with healthy snacks

___ 3 meals

___ 2 meals or less

___ Graze; small, frequent meals (*How many per day?* ______)

____ Skip breakfast or other meals

____ Generally eat on the run

____ No regular eating pattern

____ often crave sweets/carbs

Please check your current level of exercise:

___ **None**
___ **Light exercise**: 1-3 times per week, easy pace, stretching, walking, etc.
___ **Moderate exercise**: 2-3 times per week, moderate pace, some weights, etc.
___ **Heavy exercise**: 3-4 times per week, vigorous pace, weights, fast running, etc.

HEALTH INFORMATION

Past or Present Health Conditions:

DIABETES:	**Y**	**N**	HORMONE IMBALANCE:	**Y**	**N**
HYPOGLYCEMIA:	**Y**	**N**	THYROID IMBALANCE:	**Y**	**N**
STROKES:	**Y**	**N**	ANOREXIA:	**Y**	**N**
HEART DISEASE:	**Y**	**N**	BULIMIA:	**Y**	**N**
HIGH BLOOD PRESSURE:	**Y**	**N**	DRUG ADDICTION:	**Y**	**N**
PCOS (polycystic ovarian syndrome)	**Y**	**N**	Hysterectomy (Full/Partial)	**Y**	**N**

Current or previous Cancer **Y** **N** (Name of cancer) ____

ARE YOU CURRENTLY PREGNANT OR NURSING? **Y** **N**

ARE YOU ALLERGIC TO SULFA, FOOD OR MEDICATION? **Y** **N**

If you answered YES to <u>any</u> of the above, please explain: ____

____

____

Have you ever been hospitalized, under medical care, or checked into rehab for alcohol or drug treatment? **Y** **N**

If YES, please explain: ____

____

____

Please list any and all medications you are currently taking, **including doses and reasons for taking:**

____

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____

____

____

Name:____

E-mail Address:____

Check off any of the following symptoms you have experienced in the past 6 months:

- ☐ Low Back Pain
- ☐ Pain between Shoulder Blades
- ☐ Neck Pain
- ☐ Tension/Headaches
- ☐ Fibromyalgia
- ☐ Tension Across Top of Shoulders
- ☐ Numbness/Tingling in Arms/Hands
- ☐ Numbness/Tingling in Legs/Feet
- ☐ Pain in the legs
- ☐ Pain in the feet
- ☐ Tired/Fatigued
- ☐ Difficulty Sleeping
- ☐ Allergies
- ☐ Digestive Problems
- ☐ Carpal Tunnel

OTHER (explain) ____

Which of the above is the worst? ____

How long have you had it? ____

How often does it occur? ____

What does it feel like? (Describe) ____

What have you done that has helped this problem? ____

What activities would you like to do if this was not a problem? ______________________________________

Does this cause you to be:
- ☐ Moody
- ☐ Irritable
- ☐ Interrupt sleep
- ☐ Restricted in your daily activities

Does this affect your work:
- ☐ Decision making
- ☐ Poor attitude
- ☐ Decreased productivity
- ☐ Exhausted at the end of the day
- ☐ Unable to work long hours

Does this affect your life:
- ☐ Lose patience with spouse/children
- ☐ Restricted household duties
- ☐ Hinders ability to exercise or sports
- ☐ Interferes with ability to do hobbies or other activities

What have you tried to help relieve/get rid of this problem and how much did it help? (circle appropriately)

- ◆ Medications… Helped: Little Some Much
- ◆ Physical Therapy… Helped: Little Some Much
- ◆ Chiropractic… Helped: Little Some Much
- Exercise… Helped: Little Some Much
- Nutrition… Helped: Little Some Much
- Stretching… Helped : Little Some Much

OTHER ____

Location Date: Apt:

I consent to receiving a health screening. I realize that I am not receiving a diagnosis, treatment or prognosis for any condition that I may be experiencing. I acknowledge that I am receiving a demonstration only and agree to hold harmless the therapist and/or clinic from any damage resulting from this demonstration.

Signature:______________________________________**Date:**_____/____/_____

How did you hear about us? ______________________________

Do you have health insurance? Y N What kind:____

Please list any symptoms you experience that were not previously mentioned: ______________________________

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What is the most important factor in deciding to use our services? **(Circle only one)**

- **EFFECTIVENESS**: "My results are my top priority."
- **TIME**: "I want results quickly."
- **SERVICE:** "I need extra support along the way."
- **EASE**: "I have a difficult time losing weight."

I understand that my patient file will be kept completely confidential unless I give written permission for my information to be released.

Signature: ____ ***Date:*** ____________

FOR OFFICE USE ONLY

Initial Weight_________ Age______ Height___________ Ideal Weight________ Must Lose_________

Treatment Weeks________________ ½ Way Point__________________ Goal Date________________

Initial Body Fat %________________ BMI___________ Waist________

Program Director____

BP:_______/__________ Pulse:________________________ Temp:______________________

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Edit 8.19.2015