Patient Demographic Form

Please PRINT

PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial** | **Nickname/AKA**

Date of Birth | **Social Security Number** | **Gender** ☐ Male ☐ Female

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed ☐ Other | **Language** ☐ English Other: _____

Race (circle one) African American/Black | American Indian/Alaska Native | Asian | Caucasian/White | Native Hawaiian/Pacific Islander | Other

Ethnicity (circle one) Hispanic | Non-Hispanic

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ☐ Cell ☐ Pager ☐ Fax

Email Address | **Pharmacy Name and Cross Streets** | **Phone #**

Employer | **Employer Phone**

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician | **Referring Physician**

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ☐ Self (If self, skip to Emergency / Next of Kin) ☐ Spouse ☐ Parent ☐ Other

Last Name | **First Name** | **Middle Initial**

Date of Birth | **Social Security Number**

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ☐ Cell ☐ Pager ☐ Fax

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name | **First Name** | **Relationship to Patient**

Home Phone | **Work Phone** | **Other Phone** ☐ Cell ☐ Pager ☐ Fax

INSURANCE INFORMATION

Primary Insurance | **Policy Holder** | **Relationship to Patient**

Secondary Insurance | **Policy Holder** | **Relationship to Patient**

I authorize payment directly to Weigh to Wellness Denver and authorize the release of medical information necessary to process insurance claims. I voluntarily consent to treatment for myself and/or dependents. Except under certain contractual arrangements; Medicare or Medicaid, I will be responsible for the full amount of the charges at the time of service.

Signature of Patient/Responsible Person: _____ **Date:** _____

925 S Niagara St #140
Denver, CO 80224

Phone: 303-321-2383
Fax: 303-223-3288

Adult Health History Form Date: _____

Patient Name:_____
Birth date: _____ Age: _____
Primary Care Provider: _____
Referring Provider: _____
ALLERGIES: _____

History of Present Condition:

Please describe how and when your weight or nutrition problem became an issue for you?

_____
_____
_____
_____

Previous Weight Loss Attempts:

Diet type tried	Dates	Results? Short and Long term

What is your lowest adult weight ? _____ At what age?_____
What is your highest adult weight? _____ At what age? _____
What do you think is a realistic goal weight for you?_____
Reason? _____

Current Dietary Habits:

Typical Meal	Breakfast	Lunch	Dinner	Snacks/Desserts
Foods				
When/Where?				
With whom?				

How many times per week are you going out to eat?_____
Which restaurants do you frequent? _____
_____
What will you order? _____
How often do you eat Fast Food per week? (ie: McDonald's, Taco Bell)_____
What will you order? _____
How many high sugar beverages do you drink per day? (i.e. soda, juice, energy drinks)_____
How many glasses of water do you drink per day? _____

Who plans meals? _____ Shops?_____ Cooks?_____
Your favorite foods? _____
Food dislikes? _____

Current Physical Activities

Current Activity?			
Time spent?			
Frequency?			

What types of physical activities do you enjoy?_____
When does fitting exercise into your life work best?_____
Where do you like to exercise?_____

Social History

Marital Status? _____ Partner's Name/ Age/Overweight?_____
How many children or other persons are living with you? _____

What is your occupation? _____
Work Schedule: _____Commute time?_____
Activity level at work? _____sedentary ____mild activity
____moderately active __physically demanding

Tobacco Use: ___Current ___Former ____Never
If current or former, how much for how long?_____
Alcohol Use: ___Current ___Former ____Never
If current, how many alcoholic beverages do you drink per week?_____
If so, what do you like to drink and how much per serving?_____
Recreation drug use: ___Current ___Former ____Never
If current, what type?_____

What was your family culture growing up like with regards to food?
Did your family sit and eat together? _____
Were you required to "clean your plate"? _____
Did you ever experience not having enough food to eat? _____
Were you given food as a reward for good behavior or achievements? _____
Do you use food now to relieve stress or for "comfort"? _____

Past Medical History (Please circle all that apply)

Diabetes	High Blood pressure	Abnormal Cholesterol	Liver Disease	Eating Disorder
Heart Disease	Sleep Apnea	PCOS (polycystic ovarian disease)	Gout	Depression

Other Medical problems: _____

Women: Age of onset of periods? _____ Are you having periods now? _____
If yes: Are your periods regular and monthly or irregular? _____
How heavy are your periods and how long do they last?_____
Have you experienced difficulties becoming pregnant? _____
Number of pregnancies? _____ Number of live births? _____
Birth control method? _____

Past Surgical History

Surgery Type	Date
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Medications/Supplements

Please include all prescription medications, vitamins and supplements and over the counter drugs.

Name	Dosage	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Family History

Do you have any immediate family members (parents, grandparents, siblings) who have or have had any of the following conditions?

	Yes/No	**Who?**	**Type/Notes?**
Cancer			
Diabetes/ Insulin Resistance			
Heart Disease /Heart Attack			
High Cholesterol/ Hyperlipidemia			
High Blood Pressure/ Hypertension			
Overweight			
Other Significant Medical Problems			