TRILOGY MEDICAL
Centers for Integrative Medicine

PATIENT REGISTRATION FORM

LEAN TO WELLNESS PROGRAM

WEIGHT MANAGEMENT

DATE: _____

PATIENT INFO

FIRST NAME: _____LAST NAME: _____ MIDDLE INITIAL: _____

DATE OF BIRTH: _____/_____/_____ AGE: _____ MALE _____ FEMALE _____ OTHER _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

MOBILE PHONE#: _____ HOME PHONE#: _____

EMAIL: _____

EMERGENCY CONTACT

NAME: _____ PHONE #: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PRIMARY CARE PHYSICIAN

NAME: _____ PHONE #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOW DID YOU FIND US? (Please tell us who referred you so we can give them credit)

PATIENT: _____ PHYSICIAN REFERRAL: _____

INTERNET: _____ FRIEND: _____

BROCHURE: _____ NEWSPAPER/MAGAZINE: _____

OTHER: _____

SOCIAL HISTORY

Relationship status: _____ Occupation: _____

Do you have a support system of family and friends? _____

Please rate the following: (circle)

Daily stress level: Low Moderate High Too High

Enjoyment of life: Excellent Good Fair Poor

LIFESTYLE HABITS

Do you exercise? YES NO If so, what kind? _____

How often do you exercise? _____ Since when? _____

How do you feel after exercise? Energized Exhausted Other: _____

How many hours do you sleep? _____ Do you sleep through the night? _____

Do you fall asleep within 15 minutes? _____ Do you wake up feeling rested? _____

Do you wake up without an alarm? _____ How many nights/wk do you sleep through the night? _____

Do you drink alcohol: YES NO How often? _____

What type(s) of alcohol do you drink? _____

Do you use tobacco products? YES NO How often? _____

Do you use cannabis? YES NO What form? _____How often? _____

WEIGHT & DIET HISTORY

Current weight: _____ Goal weight range: _____

What has been your heaviest weight: _____ At what age? _____

What has been your lowest weight as an adult: _____ At what age? _____

Were you overweight when you were younger? YES NO What ages: _____

Have you tried to lose weight in the past YES NO Were you successful: YES NO _____

How much did you lose? _____ How long did you keep the weight off? _____

What programs/methods have you used to lose weight? _____

Additional comments: _____

Have you taken appetite suppressing medications? YES NO Which one(s)? _____

Is your spouse/partner overweight? YES NO N/A _____

Is any of your immediate family overweight? YES NO _____

Which foods do you tend to crave most? _____

Do you ever binge eat? YES NO If so, which foods and how often? _____

_____

How often do you eat out and where? _____

How many times per day do you eat? _____

Worst food habits: _____

_____

Foods you avoid: _____

Do you have any food allergies or sensitivities? YES NO Which ones: _____

_____

Are you vegetarian or vegan? YES NO If so, for how long? _____

What would you change about your body if you could?

_____

Do you get noticeably irritable, light-headed, or weak if you haven't eaten in a while? YES NO

HEALTH HISTORY

What medical conditions have you been diagnosed with? _____

_____

Have you had any operations or surgeries? YES NO If yes, please list with dates: _____

_____

Please list all of the current medications you are taking:

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to any medication? YES NO Reaction:

_____ _____

_____ _____

_____ _____

Do you take any supplements? YES NO If so, please list:

_____

_____

_____

_____

Are you currently pregnant? YES NO Are you trying to get pregnant? YES NO

If you are avoiding pregnancy, what method of contraception are you using? _____

Do you experience any of the following symptoms?

Digestive: Gas Bloating Heartburn Constipation Diarrhea Stomach pain

How many bowel movements do you have per day? _____

How is your daily energy level? Excellent Good Fair Poor

_____

Please circle any of the following that pertain to you now or in the past:

Heart disease or problems	High blood pressure	High cholesterol
Sleep apnea	Diabetes (type 1)	Diabetes (type 2)
PCOS	Thyroid condition	Migraines
Seizures	Glaucoma	Cyst of breast or ovary
Anxiety/nervousness	Depression	Emotional problems (instability or sensitivity)
Anorexia	Bulimia	Addiction (alcohol/drugs)

If yes to any of the above, please explain: _____

_____

Please circle any of the following that pertain to your Family History:

Heart disease or problems	High blood pressure	High cholesterol
Sleep apnea	Diabetes (type 1)	Diabetes (type 2)
PCOS	Thyroid condition	Migraines
Seizures	Glaucoma	Cyst of breast or ovary
Anxiety/nervousness	Depression	Emotional problems (instability or sensitivity etc)
Anorexia	Bulimia	Addiction (alcohol/drugs)

If yes to any of the above, please explain: _____

_____

Do you anticipate any specific obstacles to your being successful in losing weight and keeping it off?

Please describe: _____

_____

_____

_____

_____

NOTE:

**Please give at least 24hours (1 business day) notice for any change in appointment time.

I have answered all the questions to the best of my knowledge and consent to this program:

Patient Name (Print): _____

Patient Signature: _____

Date: _____