

# Eagle Health & Wellness

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## Weight Management Evaluation

Name \_\_\_\_\_

Age \_\_\_\_\_

Height \_\_\_\_\_

Weight \_\_\_\_\_

Weight Goal \_\_\_\_\_

### Current Providers:

Doctor's Name:

Address:

Phone:

\_\_\_\_\_

\_\_\_\_\_

Allergies: \_\_\_\_\_

### Medical Conditions/Diseases: Check all that apply

Heart Disease

Blood Clotting Problems

High cholesterol/lipids

Diabetes

High blood pressure

Arthritis or joint problems

Cancer

Depression/Anxiety

Ulcers

Epilepsy

Thyroid Disease

Headaches/Migraines

Hormonal/Menstrual issues

Eye Disease

Lung Conditions

Other: \_\_\_\_\_

Have you undergone any surgeries? Please list \_\_\_\_\_

### For Females Only:

How many pregnancies have you had? \_\_\_\_\_

How many children? \_\_\_\_\_

Have you undergone hysterectomy or removal of ovaries? If yes, what was the reason for surgery and date? \_\_\_\_\_

When was your last menstrual period? \_\_\_\_\_ How many days did it last? \_\_\_\_\_

Do you ever have irregular cycles or abnormal cycles? \_\_\_\_\_

**Family History:**

Do you have any of the following in your family?

	Yes/No	Family Member(s)
Cancer	_____	_____
Heart Disease	_____	_____
Diabetes	_____	_____
Stroke	_____	_____
Other Diseases	_____	_____

**Social History:**

Tobacco Use: \_\_\_ yes \_\_\_ no      Amount per day: \_\_\_\_\_      Past Use: \_\_\_\_\_  
 Alcohol Use: \_\_\_ yes \_\_\_ no      Amount per day: \_\_\_\_\_      Past Use: \_\_\_\_\_  
 Drug Use: \_\_\_ yes \_\_\_ no      Type used: \_\_\_\_\_      Past Use: \_\_\_\_\_

**Medication History:**

Please list any over the counter (OTC) products used regularly or occasionally:

\_\_\_\_\_

Please list any supplements or vitamins used regularly or occasionally:

\_\_\_\_\_  
\_\_\_\_\_

**Current Prescription Medications:**

Name: \_\_\_\_\_ Strength: \_\_\_\_\_ Times per day: \_\_\_\_\_ Date started: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Weight History:**

At what age did you first have trouble with weight? \_\_\_\_\_

What was your highest weight and at what age? \_\_\_\_\_

What was your lowest adult weight and at what age? \_\_\_\_\_

What do you consider to be barriers to weight loss? \_\_\_\_\_  
\_\_\_\_\_

Have you ever suffered from an eating disorder such as bulimia or anorexia? \_\_\_\_\_

**What are the previous diets/weight loss plans you have tried?**

Name: \_\_\_\_\_ Dates: \_\_\_\_\_ Weight loss: \_\_\_\_\_ Reason for failure: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Medical Concerns and Review of Systems:**

	Absent	Mild	Moderate	Severe
Weight Gain	_____	_____	_____	_____
Heavy/Irregular Menses	_____	_____	_____	_____
Hot Flashes	_____	_____	_____	_____
Dry Skin/Hair	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Night Sweats	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Irritability	_____	_____	_____	_____
Mood Swings	_____	_____	_____	_____
Sleep Trouble/Insomnia	_____	_____	_____	_____
Cramps	_____	_____	_____	_____
Fluid Retention	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____
Loss of Memory	_____	_____	_____	_____
Bladder Symptoms	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Decreased Sex Drive	_____	_____	_____	_____
Hair Loss	_____	_____	_____	_____
Constipation	_____	_____	_____	_____
Irregular/Irritable Bowels	_____	_____	_____	_____

Please list any other problems you are having today: \_\_\_\_\_  
\_\_\_\_\_

**Physical Assessment:**

Do you have any aches or pains? Yes \_\_\_\_\_ No \_\_\_\_\_  
Do you limit your activities due to discomfort or pain? Yes \_\_\_\_\_ No \_\_\_\_\_  
Have you had previous chiropractic care? Yes \_\_\_\_\_ No \_\_\_\_\_