Patient Label

New Patient Intake Form
Calgary Metabolic Recovery Clinic

www.calgarymrc.ca

Date: ____
Patient Name: ____
Healthcard Number (PHN):__________________________________
Date of Birth:____

How did you find out about this clinic?
- ❑ Friend/Family/Co-worker
- ❑ Internet
- ❑ Physician referral
- ❑ Other:_________________________

Current Height: __________ cm/ ft
Current Weight: __________kg /lb
Weight 1 year ago: ________ kg/ lb
Highest adult weight: ________kg/ lb
Lowest adult weight: ________kg/ lb

Please list any past or current health conditions, illnesses, and/or hospitalizations you have had including:

- ❑ Diabetes
- ❑ Pre-Diabetes
- ❑ High blood pressure
- ❑ Heart Failure
- ❑ Sleep Apnea
- ❑ High Cholesterol
- ❑ Polycystic Ovarian Syndrome (PCOS)
- ❑ Thyroid disease
- ❑ Fatty Liver
- ❑ History of bariatric surgery
- ❑ Asthma
- ❑ COPD
- ❑ Anxiety
- ❑ Depression
- ❑ Bipolar disorder
- ❑ Osteoarthritis
- ❑ Rheumatoid Arthritis
- ❑ Fibromyalgia
- ❑ Eating disorders
- ❑ Gout
- ❑ Kidney Disease
- ❑ Kidney Stones
- ❑ Liver disease
- ❑ Glaucoma
- ❑ Pancreatitis
- ❑ Pulmonary Embolism
- ❑ Epilepsy
- ❑ Stroke

Do you have any other health conditions not listed above? If yes, please specify: _____________
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Please list any allergies (environmental, pet, medication, etc):
____
____
____
____

What is your current occupation? ____

Do you have any children? If yes, how many? ____________________________________

Are you currently in a relationship?
- ❑ Yes If yes, please describe (married, common law, etc):______________________________
- ❑ No

If you are female, are you pregnant?
- ❑ Yes
- ❑ No
- ❑ I don't know

If you are female, are you trying to become pregnant?
- ❑ Yes
- ❑ No
- ❑ I'm thinking about it

What are your current goals with respect to your overall health? Mark all that apply:
- ❑ Improve Health / Feel Better
- ❑ Increase Energy
- ❑ Allow me to do more daily activities
- ❑ Lose weight
- ❑ Prevent medical problems
- ❑ Reverse medical problems, and possibly allow me to stop medications
- ❑ Other goals:____
  ____

Have you ever had weight loss surgery?
- ❑ Yes
- ❑ No

If yes, what type?______________________ Date of surgery:____________________

Are you interested in weight loss surgery?
- ❑ Yes
- ❑ No
- ❑ Not sure

Are there any factors that increased weight or worsened health conditions for you in the past? Please list all that apply

- ❑ Death or Illness of Family or Friend:____
- ❑ Illness:____
- ❑ Injury:____
- ❑ Quitting smoking:____
- ❑ Menopause:____
- ❑ Medications:____
- ❑ Stress:____
- ❑ Other factors not listed here:____

Please list all current medications, including prescriptions, over-the-counter, supplements, etc:

Medication	Dose	Times per day

Do you currently, or have you ever used tobacco products including cigarettes, cigars, vape, or chewing tobacco?

- ❑ Yes
- ❑ No

If yes, how much to you typically consume per day and for how long have you been consuming tobacco?

____

____

If you have quit smoking or consuming tobacco, when did you quit?____________________

Do you currently or have you ever consumed alcohol?
- ❑ Yes
- ❑ No

If yes, how much do you typically drink per day/week/month and how long have you been consuming it in this way?

____

____

If you have quit drinking alcohol, when did you quit?_______________________________

Do you currently or have you ever consumed recreational drugs, including marijuana or cannabis?
- ❑ Yes
- ❑ No

If yes, how much do you typically consume per day/week/month and how long have you been consuming it in this way?

____

____

If you have stopped using recreational drugs, when did you quit?___________________

Do you currently or have you ever consumed caffeine (e.g. coffee, tea, etc)?
- ❑ Yes
- ❑ No

If yes, how much do you typically consume per day/week/month?

____

____

Are any of your family members overweight or have obesity?
- ❑ Yes
- ❑ No

Will your family and/or friends support you in your lifestyle changes?
- ❑ Yes
- ❑ No

Are you mostly sitting or standing at work?
- ❑ Standing
- ❑ Sitting
- ❑ Both sitting and standing equally

Do you have any **Family History** of the following?

- ❑ Obesity (high weight or overweight)
- ❑ Hypertension (high blood pressure)
- ❑ Diabetes (high blood sugar)
- ❑ High Cholesterol
- ❑ Obstructive Sleep Apnea
- ❑ Heart disease or Heart conditions
- ❑ Arthritis
- ❑ Asthma
- ❑ Cancer
- ❑ Anxiety
- ❑ Depression
- ❑ Other conditions:
  ____
  ____
  ____

Dietary Habits:

On average, how many meals do you eat per day? ______________________________

On average, how often do you snack per day? ______________________________

Please describe an average meal for you, if applicable:

Breakfast:
Lunch:
Dinner:
Snack(s):

On average, how many cups of **water** do you drink per day? ____________________________

On average, how many cups of **sugar sweetened beverages** such as juice, soda pop, iced tea, do you drink per day/week/month/year? ________________

Have you tried any **specific types of diets** so far? Some examples are DASH diet, Mediterranean Diet, Low Fat Diet, South Beach Diet, Ketogenic Diet, Low Carb High Fat, Low calorie diet, Vegan, Vegetarian, Nutrisystem, Atkins, Slimfast, and many others:

- ❑ Yes
- ❑ No

If yes, which diets have you tried, and for how long? What were the results you achieved?

____
____
____
____

Do you have any food allergies or intolerances?

- ❑ Yes
- ❑ No

If yes, please specify:

____
____
____

Do you have any dietary restrictions, such as religious, vegetarian, vegan, celiac, or other restrictions?

- ❑ Yes
- ❑ No

If yes, please specify:

____
____
____

How often do you eat out? ____

What kind of restaurants do you choose when you decide to eat out?

____
____
____

Do you ever find that you eat in the following situations? Please mark all that apply:

- ❑ Eating when stressed, emotional, or bored
- ❑ Binge Eating
- ❑ Grazing or Frequent Snacking
- ❑ Eating in the middle of the night
- ❑ Eating in front of the TV or computer
- ❑ Eating at desk, or computer, or while working
- ❑ Eating too fast
- ❑ Do not feel satisfied or full after a meal

Please list any past weight loss programs or wellness programs that you have tried, if any:

____

____

____

Were you successful with these programs? Were you able to keep the weight off? Did your health conditions improve? How did these programs work for you?

____

____

____

How confident are you that you can change the way you eat to improve your health?

- ❑ Very confident
- ❑ Moderately confident
- ❑ Only a little confident
- ❑ Not at all confident

What are your current barriers to changing the way you eat to improve your health? Please mark all that apply:

- ❑ Access to healthy foods
- ❑ Access to refrigerator and/or freezer
- ❑ Healthy food doesn’t taste good
- ❑ Access to cooking appliances (stove, microwave, grill, etc)
- ❑ Food intolerances
- ❑ Cost of food
- ❑ Family/household dietary restrictions
- ❑ Lack of family or peer support
- ❑ Lack of knowledge of food to eat and buy
- ❑ Time to plan and prepare a healthy diet

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Who does the grocery shopping?

- ❑ Self
- ❑ Spouse
- ❑ Parent
- ❑ Other:____________________

Who cooks and/or prepares the meals?

- ❑ Self
- ❑ Spouse
- ❑ Parent
- ❑ Other:_____________________

Sleeping habits:

Do you sleep well?

- ❑ Yes
- ❑ No

If no, please describe why:

____

____

____

On average, how many hours of sleep do you have per night?_________________________

Do you wake up feeling refreshed?

- ❑ Yes
- ❑ No

If no, please describe why:

____

____

Do you wake up at night?

- ❑ Yes
- ❑ No

If yes, please describe why and how often this occurs:

____

____

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Physical Activity:

When was the last time you participated in physical activity? ______________________________

What kind of physical activities do you enjoy doing?_____________________________________

Do you have any negative feelings about physical activities or had any negative experiences with exercise?

- ❑ Yes
- ❑ No

If yes, please describe:

____

____

Do you have any injuries or conditions that prevent you from participating in physical activities?

- ❑ Yes
- ❑ No
- ❑ I'm not sure

If yes, please specify:

____

____

How much exercise have you done in the past week?

- Type of exercise____
- Length of exercise: __________minutes _____________ times per week

What type of exercise are you currently involved in? Mark all that apply

- ❑ Aerobics classes
- ❑ Exercise videos
- ❑ Water/pool exercise
- ❑ Biking, outdoor
- ❑ Biking, stationary
- ❑ Hiking
- ❑ Pilates
- ❑ Yoga
- ❑ Weight training
- ❑ Running
- ❑ Zumba
- ❑ Boot camp
- ❑ Crossfit
- ❑ Stretching
- ❑ Swimming
- ❑ Walking
- ❑ Elliptical machine
- ❑ Barre
- ❑ None
- ❑ Other forms not listed:

____

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How confident are you that you could increase the amount of exercise you do?
- ❑ Very confident
- ❑ Moderately confident
- ❑ Only a little confident
- ❑ Not at all confident

What are your current barriers to increasing the amount of exercise you do? Mark all that apply
- ❑ Lack of motivation
- ❑ Lack of time
- ❑ Lack of equipment
- ❑ Lack of access to fitness facilities
- ❑ Injuries
- ❑ Health problems
- ❑ Other barriers:____

Do you have any hobbies or other activities that you enjoy doing?
- ❑ Yes
- ❑ No

If yes, please describe:

____

____

Stress:

On average, how would you rate your average daily stress level out of 10, with 1 being low stress and 10 being high stress? Please circle:

1 2 3 4 5 6 7 8 9 10

How do you cope with stressful situations in your life?

____

____

On a scale of 1-10, with 10 being the MOST committed, how committed are you to making a change in your life to achieve your health goals? Please circle:

1 2 3 4 5 6 7 8 9 10

What do you think will help you achieve your goals?

____

____

Thank you for taking the time to fill out this new patient intake form prior to our appointment together. This information will remain confidential and will enable me to learn more about you and your current health goals prior to our appointment.