



# Best Life Initial Assessment Packet

Updated: May 19,2014

PATIENT INFORMATION			
NAME IN FULL	<input type="checkbox"/> F <input type="checkbox"/> M	AGE	DATE OF BIRTH
TODAY'S DATE			
ADDRESS			
CITY	COUNTY	STATE	ZIP CODE
HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	CELL NUMBER	MARITAL STATUS
OCCUPATION	EMPLOYER		
REASON FOR APPOINTMENT	REFERRED BY /HOW DID YOU HEAR ABOUT US		
COMPLETE IF PATIENT IS A MINOR			
MOTHER'S NAME	FATHER'S NAME		
CUSTODY	LIVES WITH		
<input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other	<input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other		
PARENT'S/CONTACT'S TELEPHONE NUMBER	TELEPHONE NUMBER FOR		
EMERGENCY CONTACT			
NAME	RELATIONSHIP TO PATIENT	HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER
ADDRESS	CITY	STATE	ZIP CODE
CONTACTS			
PRIMARY CARE PHYSICIAN	SPECIALTY	LAST APPOINTMENT	HOW LONG HAVE THEY TREATED YOU?
CITY	STATE	PHONE NUMBER	
PSYCHIATRIST			
PSYCHIATRIST	LAST APPOINTMENT	HOW LONG HAVE THEY TREATED YOU?	
CITY	STATE	PHONE NUMBER	
THERAPIST			
THERAPIST	LAST APPOINTMENT	HOW LONG HAVE THEY TREATED YOU?	
CITY	STATE	PHONE NUMBER	
HOW OFTEN DO YOU MEET?	DO YOU FIND IT HELPFUL?		
IF NOT CURRENTLY IN THERAPY, HAVE YOU BEEN IN THE PAST?	IF SO, WAS IT HELPFUL?		
NUTRITION THERAPIST			
NUTRITION THERAPIST	LAST APPOINTMENT	HOW LONG HAVE THEY TREATED YOU?	
CITY	STATE	PHONE NUMBER	
HOW OFTEN DO YOU MEET?	DO YOU FIND IT HELPFUL?		
IF NOT CURRENTLY IN THERAPY, HAVE YOU BEEN IN THE PAST?	IF SO, WAS IT HELPFUL?		

# Medical/Psychology History

MEDICAL AND MENTAL HEALTH PROBLEMS for which you are being treated:		
PROBLEM	DOCTOR	HOW TREATED
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

SURGERIES you have had:	
SURGERY	WHEN
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

MEDICATIONS and over-the-counter pills you are taking:		
NAME OF MEDICATION	DOSAGE	HOW OFTEN TAKEN
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

ALLERGIES:	
Are you allergic to any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No    If so please list:	
DRUG	PROBLEM
1.	
2.	
3.	
4.	
5.	

Do you have any food allergies?     Yes     No    If so please list:

## Current Medical Concerns

Check all that apply

### Cardiovascular

<input type="checkbox"/>	Heart problems	Requiring medication?
<input type="checkbox"/>	Chest pains	
<input type="checkbox"/>	Racing heart/skipping	
<input type="checkbox"/>	High blood pressure	Requiring medication?
<input type="checkbox"/>	Chest tightness	
<input type="checkbox"/>	Shortness of breath	
<input type="checkbox"/>	High cholesterol	Requiring medication?
<input type="checkbox"/>	High triglycerides	Requiring medication?
<input type="checkbox"/>	Feel tired all the time	

### Diabetes

<input type="checkbox"/>	Diabetes - Type I or II	Requiring medication?
<input type="checkbox"/>	Pre-diabetic	Elevated blood sugar?
<input type="checkbox"/>	Gestational diabetes	Age of Diagnosis?
<input type="checkbox"/>	Hypoglycemia (low blood sugar)	

### Thyroid Problems

<input type="checkbox"/>	Hypothyroidism
<input type="checkbox"/>	Hyperthyroidism

### Gastrointestinal

<input type="checkbox"/>	Gallbladder problems	Removed?
<input type="checkbox"/>	Stomach ulcers	Requiring medication?
<input type="checkbox"/>	Heartburn	Daily? Nocturnal?
<input type="checkbox"/>	Regurgitation	Requiring medication?
<input type="checkbox"/>	Diarrhea	Requiring medication?
<input type="checkbox"/>	Constipation	Requiring medication?

### Respiratory

<input type="checkbox"/>	Asthma	Last attack?	
<input type="checkbox"/>	Bronchitis	# of times in past 2 years	Is it recurring?
<input type="checkbox"/>	Pneumonia	# of times in past 2 years	
<input type="checkbox"/>	Blood clots in lungs		
<input type="checkbox"/>	Smoker	Starting age?	When did you stop?
<input type="checkbox"/>	Smokeless tobacco		
<input type="checkbox"/>	Snore		
<input type="checkbox"/>	Wake up gasping or with a smothered feeling		

### Musculoskeletal

Location	Mild	Moderate	Severe
Hip pain			
Knee pain			
Ankle pain			
Feet pain			
Back pain			
Neck pain			
Arthritis			

### Females Only - Menstrual History

Are you currently menstruating?  Yes  No  Have never menstruated

Date of last menstrual cycle \_\_\_\_\_

Are your periods regular? \_\_\_\_\_

Any difficulty conceiving? \_\_\_\_\_

Are you taking birth control pills/patches/injections or utilizing another form of birth control to prevent pregnancy? \_\_\_\_\_ If so, what? \_\_\_\_\_

Are you currently breast feeding? \_\_\_\_\_

How many times have you been pregnant? \_\_\_\_\_ How did you deliver? \_\_\_\_\_

# Family and Social History

**Did you ever experience any of the following during your childhood or adolescence?**

**FAMILY:**

- Death of a parent
- Death of other loved one or close friend
- Life threatening illness in immediate family
- Separation from a parent for > a month
- Parent's separation/divorce
- Loss of home through natural disaster
- Family financial problems
- Parent with substance abuse problem
- Significant conflict with parents
- Foster care

**ABUSE/TRAUMA:**

- Physical abuse
- Sexual abuse
- Verbal/Emotional abuse
- Neglect
- Rape
- Other traumatic event
- If yes, please explain: \_\_\_\_\_

**EDUCATION:**

- What's the farthest you've gone in school? \_\_\_\_\_
- What grades did you make in school? \_\_\_\_\_

**What is your occupation/career? How long have you worked in this capacity?** \_\_\_\_\_

**What, if any, legal problems have you had?** \_\_\_\_\_

**What stresses are in your life now?** \_\_\_\_\_

**What is your current living situation?** \_\_\_\_\_

**Describe your social support system:** \_\_\_\_\_

**Are you currently married?**  Yes  No      How many times have you been married? \_\_\_\_\_

**How many children do you have?** \_\_\_\_\_      Their ages: \_\_\_\_\_

Have you ever been hospitalized for mental illness or substance abuse:  yes  no  
If yes, **please explain:**

**Please check which substances you have used in your lifetime:**

	Current	Past	Date of last use:		Current	Past	Date of last use:
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>		Amphetamines/stimulants	<input type="checkbox"/>	<input type="checkbox"/>	
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>		Tranquilizers/benzos (Ativan, Klonopin, Xanax)	<input type="checkbox"/>	<input type="checkbox"/>	
Marijuana/Spice/ K2	<input type="checkbox"/>	<input type="checkbox"/>		Opiates/pain pills	<input type="checkbox"/>	<input type="checkbox"/>	
Cocaine/ crack	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
Heroin	<input type="checkbox"/>	<input type="checkbox"/>		Soma/muscle relaxants	<input type="checkbox"/>	<input type="checkbox"/>	
GHB	<input type="checkbox"/>	<input type="checkbox"/>		Ultram/tramadol	<input type="checkbox"/>	<input type="checkbox"/>	
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>		Inhalants	<input type="checkbox"/>	<input type="checkbox"/>	
LSD or Mushrooms	<input type="checkbox"/>	<input type="checkbox"/>		Nitrous oxide	<input type="checkbox"/>	<input type="checkbox"/>	
PCP	<input type="checkbox"/>	<input type="checkbox"/>		IV Drugs:	<input type="checkbox"/>	<input type="checkbox"/>	
Ketamine (special "K")	<input type="checkbox"/>	<input type="checkbox"/>		Other:	<input type="checkbox"/>	<input type="checkbox"/>	

**Please answer the following:**

	Yes	No
How many drinks do you need to feel a buzz/"high"? _____		
Are you or others concerned with how much you drink?	<input type="checkbox"/>	<input type="checkbox"/>
Do you need a drink in the morning?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have periods of time you don't remember associated with your drinking?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever blacked out from drinking?	<input type="checkbox"/>	<input type="checkbox"/>
Have you tried to cut down your drinking?	<input type="checkbox"/>	<input type="checkbox"/>

# Weight & Diet History:

How do you feel about your body?:

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Describe in your words how obesity is affecting your life:

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What is your primary motivation for losing weight?

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What do you think is the primary reason for your weight gain?

\_\_\_injury                      \_\_\_ lack of exercise                      \_\_\_ pregnancy                      \_\_\_overeating  
\_\_\_poor eating habits                      \_\_\_ heredity                      \_\_\_ marriage                      \_\_\_ stress  
\_\_\_smoking cessation                      \_\_\_ divorce                      \_\_\_ food addiction

What is your **highest** weight?                      \_\_\_ lbs                      when? \_\_\_\_\_

What is your **lowest** weight?                      \_\_\_ lbs                      when? \_\_\_\_\_

What is your desired weight range?                      \_\_\_ lbs to                      \_\_\_ lbs

## Activity/Exercise History:

### What is your regular activity level:

Minimally active: (very sedentary, rarely leave the house)	<input type="checkbox"/>
Somewhat active: (light housework, gardening, walking on errands or while working)	<input type="checkbox"/>
Moderately active: (exercise 1-3 times a week, walking for exercise)	<input type="checkbox"/>
Very active: (exercise 3 or more times a week, e.g. aerobics, running, swimming, weight training, cycling)	<input type="checkbox"/>
Extremely active: (daily vigorous exercise)	<input type="checkbox"/>

What are your favorite activities or exercises?

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What physical activities are you currently engaged in? \_\_\_\_\_

### Meals:

How many meals per day do you eat?

\_\_\_ 1 meal    \_\_\_ 1-2 meals    \_\_\_ 2 meals    \_\_\_ 2-3 meals    \_\_\_ 3 meals    \_\_\_ 3 or more meals

**Do you skip meals?**    \_\_\_yes    \_\_\_no

If yes, what meal(s) do you usually skip? \_\_\_\_\_

How many days a week do you skip this meal? \_\_\_\_\_

Do you skip meals to control your weight? \_\_\_\_\_

**Are your meals:**

large portions  extra large portions  high fat  high in carbs  high in sugar

**How often do you snack:**

a.m. snack  p.m. snack  evening snack  snack between all meals

**What are your favorite snacks?** \_\_\_\_\_

**What beverages do you drink?**

water  whole milk  2% milk  1% milk  
 skim milk  regular soda  diet soda  regular coffee  
 decaf coffee  regular tea  decaf tea  juice  
 sweet tea  unsweetened tea

**How often do you eat out?** \_\_\_\_\_

**Do you eat rapidly?**  yes  no

**Do you eat in secret or hide food?**  yes  no

If yes, why? \_\_\_\_\_

**Do you consider yourself a binge eater?**  yes  no

If yes, what do you consume during a binge?  
\_\_\_\_\_  
\_\_\_\_\_

If yes, how often do you binge? \_\_\_\_\_

If yes, do you feel out of control when you binge?  yes  no

**Do you eat large amounts of food when you're not hungry?**  yes  no

**Do you eat more than you intended to at one sitting?**  yes  no

**Do you feel guilty after you have eaten?**  yes  no

If yes, why? \_\_\_\_\_

**Do you feel like you're an emotional eater?**  yes  no

If so, please describe: \_\_\_\_\_

**Have you ever used laxatives to assist with weight loss?**  yes  no

**Have you ever used diuretics for weight loss?**  yes  no

**Do you induce vomiting?**  yes  no If yes, how many times a day? \_\_\_\_\_

**Do you exercise excessively to compensate for food you have eaten?**  yes  no

**About how many calories do you think you eat a day?** \_\_\_\_\_

**How hungry do you let yourself get:**

(not hungry at all) 0---1---2---3---4---5---6---7---8---9---10 (so hungry you get cramps)

## Dieting History

When did your weight problem begin? \_\_\_\_\_

Have you ever tried to control your weight?  Yes  No

If yes, age at first attempt: \_\_\_\_\_ years

Your height at that time: \_\_\_\_\_ Your weight at that time: \_\_\_\_\_

Why did you go on the diet?

\_\_\_\_\_

\_\_\_\_\_

### Which diets have you tried:

Weight Watchers	<input type="checkbox"/>	Food Pyramid	<input type="checkbox"/>	Beverly Hills diet	<input type="checkbox"/>
Nutri/System	<input type="checkbox"/>	Diabetic diet	<input type="checkbox"/>	Scarsdale Diet	<input type="checkbox"/>
Jenny Craig	<input type="checkbox"/>	Liquid Diet	<input type="checkbox"/>	Hollywood 48 hour diet	<input type="checkbox"/>
LA Weight Loss	<input type="checkbox"/>	Optifast	<input type="checkbox"/>	Celebrity diet	<input type="checkbox"/>
Richard Simmons	<input type="checkbox"/>	Body For Life	<input type="checkbox"/>	The Grapefruit diet	<input type="checkbox"/>
Slimfast	<input type="checkbox"/>	Fit For Life	<input type="checkbox"/>	Cabbage soup diet	<input type="checkbox"/>
Metabolife	<input type="checkbox"/>	Medifast	<input type="checkbox"/>	Mediterranean diet	<input type="checkbox"/>
Atkins	<input type="checkbox"/>	Mayo Clinic diet	<input type="checkbox"/>	Subway diet	<input type="checkbox"/>
HCG Diet	<input type="checkbox"/>	Pritkin diet	<input type="checkbox"/>	Fasting	<input type="checkbox"/>
The Zone	<input type="checkbox"/>	Raw diet	<input type="checkbox"/>	Caveman diet	<input type="checkbox"/>
South Beach	<input type="checkbox"/>	Blood Test diet	<input type="checkbox"/>	Low Calorie	<input type="checkbox"/>
Low Carb diet	<input type="checkbox"/>	Negative Calorie diet	<input type="checkbox"/>	_____	how many calories a day
Sugar Busters diet	<input type="checkbox"/>	Cider Vinegar diet	<input type="checkbox"/>	Other diets:	

What has been your most successful diet?

\_\_\_\_\_

Why do you suppose this was the case?

\_\_\_\_\_

Have you ever seen a nutritionist? \_\_\_yes \_\_\_no

What were their recommendations?

\_\_\_\_\_

Were their recommendations helpful? \_\_\_\_\_

Have you ever taken medications for weight loss (either over the counter or prescription)? \_\_\_\_\_

If so, what have you taken?



