Dr. Rebecca Andrick drandrick@wtwdenver.com **303-321-2383**

Adult Health History Form

Date: ______________

Please use blue or black ink, thank you.

Patient Name:____

Birth date: ______________ Age: _________

Primary Care 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 weight and how old were you? _____________Maximum?__________

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?_____________________________

How often do you eat Fast Food per week? (ie: McDonald's, Taco Bell)_______________

What will you order? ____

Which "sit down" restaurants do you frequent? ________________________________

How many high sugar beverages do you drink per day? (i.e. soda, juice, energy drinks)________
Who plans meals? ______________Shops?_______________ Cooks?____________________
Your favorite foods? ____
Food dislikes? ____

Current Physical Activities

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

Do you smoke? How much for how long?____
How many alcoholic beverages do you drink per week?_______________________________
If so, what do you like to drink and how much per serving?___________________________
Do you use any Recreational drugs? 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? _______________________________

Past Surgical History

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

Medications

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

Relative	Age	Living	Medical Problems? Are they Overweight?
Mother			
Father			
Sibling (sis or brother?			
Sibling			
Sibling			
Mother's Mother (GM) Mother's Father (GF)			
Father's Mother (GM) Father's Father (GF)			
Children			
Children			
Children			
Family with early onset of heart disease/ cancer			

Review of Systems (circle all that apply)

of Sleep hours/night________ Bedtime?____________ Wake time?_____________ Snoring Apnea (waking due to stopping breathing) Fever Chills Night sweats Hot Flashes Fatigue Weakness
Neck or jaw swelling Chronic nasal congestion Difficulty swallowing
Chest pain (if yes, with or without activity?) Shortness of breath with activity Palpitations Jaw, shoulder or arm pain with activity?
Wheezing of cough with physical activity? Chronic cough Shortness of breath at rest
Heartburn Constipation Diarrhea Blood in Stools Excess Gas Nausea Vomiting Abdominal Pain
Excessive thirst Excessive Water intake Hair loss Intolerance of heat or cold
Frequent urination Large volumes of urine Blood in urine Waking to Urinate Men only: Problems with Erections
Numbness or Tingling in Extremities Burning or Pain in Extremities Headaches
Joint Pain (Which? ______________________) Muscle Pain (Where? ________________) Swelling in extremities (Where?___________________________)
Feeling sad Feeling anxious Excessive Stress Binging on Food Sleep Disturbed Insomnia Guilt or Shame After Eating Hiding Food
Acne Skin Rash Dark Skin lesions in folds of skin
Women only: Excess facial hair Nipple hair Lower Abdominal hair Nipple Discharge

Preventative Medical Care Status

Date of most recent blood work? Where done? ____________________________________

Test/Exam	Date	Nl.	Abn.	Results
Physical				
Lipid Profile				Tot. LDL HDL Trig.
TSH/Thyroid test				
Stool test for blood				
Colon Screening?				
Pap Smear				
Mammogram				
PSA				
EKG				
Treadmill				
Hgb A1C				

Nutrition and Fitness for
Weight Management
for Adults, Children and Families

Name: ______________________________________

Date: ______________________

Welcome! Please help us get to know you.

1. I am here for assistance with:

- Weight Reduction
- Gastrointestinal Issues
- Bariatric Surgery Preparation or Follow Up
- Nutritional Deficiencies
- Food Allergies
- Food Sensitivities
- Other _____________________

2. If you're here for weight reduction, tell us what you are looking for:

- I'd like to lose 1 lb. per week (moderate calorie deficit)
- I'd like to lose 2 lbs. per week (more significant calorie deficit)
- I'd like to lose 3 lbs. or more per week (very low calorie diet)
- Other ______________________________________

3. Tell us how we can help you best achieve your goals: (circle all that apply)

My Knowledge of Nutrition is:	Minimal to Fair	Fair to Good	Great
I need a meal plan that is:	Flexible	More Specific	Very Structured
Weight loss medication options:	Interested	Not Interested	I would like to know more
Discuss Bariatric surgery:	Interested	Not Interested	I would like to know more
I'd like to meet with an exercise physiologist:	Interested	Not Interested	I would like to know more
Treatment for emotional eating:	Interested	Not Interested	I would like to know more

4. I work best if I have: (check all that apply)

- Something structured to follow
- Guidance with flexibility to follow an individual program
- Frequent Visits (weekly, bimonthly, monthly) to suit my needs
- Specific goal setting intervals (long and short term)
- Immediate results, so I don't give up

5. I follow a diet that is (check all that apply)

- Gluten Free
- Dairy Free
- Vegetarian
- Clean, little processed food
- Food Allergy Restricted
- Low Carb/High Protein
- Other _____________________

6. **Anything else you would like us to know about you?** ___________________________________

____

____

7. Rate your Plate (put a check mark in the column (A,B, or C) that applies to you)

Topic	A	B	C
Red Meat: Beef, hamburger, pork, lamb, veal	**Usually Eat:** Three times a week or more	**Usually Eat:** Twice a week	**Usually Eat:** Once week or less
Chicken, Turkey, etc.	**Usually Eat:** Chicken, turkey and other poultry with skin	**Sometimes Eat:** Chicken, turkey and other poultry with skin	**Usually Eat:** Chicken, turkey and other poultry without skin
Fish	**Usually Eat**: less than once a week	**Usually Eat:** once a week	**Usually Eat**: twice a week or more
Cold cuts, hot dogs, breakfast meats	**Usually Eat:** Salami, bologna, other cold cuts, hot dogs, bacon, sausage	**Sometimes Eat:** Salami, bologna, other cold cuts, hot dogs bacon, sausage	**Usually Eat:** lean deli meat or, I **rarely eat** processed meat
Portion Sizes	Large	Medium	Small
Eating out: restaurants or fast food	**Usually Eat:** Three or more times per week	**Usually Eat:** 1-2 times per week	**Usually Eat:** Once a week or less
Milk	**Usually Drink:** Whole milk or cream	**Usually Drink:** 2% reduced fat milk	**Usually Drink:** 1% low-fat or skim milk
Dairy Servings per day	**0-1**	**1-2**	**2-3**
Cooking method	**Usually Add:** Oil, butter or margarine to the pan	**Sometimes Add:** oil, butter or margarine to the pan	**Usually Use:** Cooking spray, minimal olive or canola oil
Fried foods	**Usually Eat:** Fried foods	**Sometimes Eat:** Fried foods	**Rarely Eat:** Fried Foods
Spreads, condiments, dressings	**Large Amount or Frequently:** Creamy salad dressings, butter, high fat sauces and and/or gravy	**Moderate Amount or Sometimes:** Creamy salad dressings, butter, high fat sauces and/or gravy	**Small Amount:** Light dressings, margarine and lower fat sauces
Snacks	**Usually Eat:** Chips and/or crackers	**Sometimes Eat:** Chips and/or crackers	**Rarely Eat:** Chips and/or crackers
Desserts & sweets	**Usually Eat:** Donuts, cookies, cake, pie, pastry, chocolate or ice cream	**Sometimes Eat:** Donuts, cookies, cake, pie, pastry, chocolate or ice cream	**Usually Eat:** Fruit, low-fat or sugar free desserts
Grains	**Usually Eat:** White breads, white rice and/or low fiber cereals	**Sometimes Eat:** White breads, white rice and/or low fiber cereals	**Usually Eat:** Whole grain breads, brown rice and whole grain cereals
Fruits & Vegetables	**Usually Eat:** 1 serving or less per day	**Usually Eat:** 2-4 servings per day	**Usually Eat:** 5 or more servings per day
Sugar Sweetened Beverages	**Usually Drink**: 12 oz. or more of soda, juice, or other sweetened beverage a day	**Occasionally Drink:** soda, juice, or other sweetened beverage	**Usually Drink:** unsweetened or diet drinks, or water

Find your Rate Your Plate Score:

Total checks in Column A _________ X1 = __________

Total checks in Column B _________ X2 = __________

Total checks in Column C _________ X3 = __________

Total Score: __________

What does your score mean?

If your score is:

15-20 There are many ways you can make your eating habits healthier.

20-35 There are some ways you can make your eating habits healthier.

35-48 You are making many healthy choices.

What areas of your diet could be improved?

1. ______________________________
2. ______________________________
3. ______________________________

Authorization to Use or Disclose My Health Information

Patient name:____ **Date of Birth:**______________________

I. Authorization for my PCP and or referring physician(s)____

You may use or disclose the following health care information (check all that apply):

Recent Laboratory Reports (last 1 year)

Recent Testing Reports: ____

Any health information maintained by the above named physician/practice regarding: ______________________

____

You may disclose this health information to:

Weigh To Wellness Denver
Rebecca Andrick, D.O.
925 S. Niagara St. Suite #370
Denver, CO 80224

Phone: (303) 321-2383

FAX: (303) 223-3288

Reason(s) for this authorization (check all that apply):
____At my request
____Other (continuity of care)____
This authorization ends: (on date)____
II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form:

- To take part in a research study
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

____ ________________________ __________
Patient or Legally Authorized Individual Signature **Date** **Time**

Rebecca M. Andrick, D.O.

925 S. Niagara St. Suite #370. Denver, CO. 80224
Phone: (303) 321-2383 Fax: (303) 223-3288

REVIEW THIS FORM THOROUGHLY; COMPLETE ALL INFORMATION IN BLACK OR BLUE INK; SIGN THE FORM -- THANK YOU

Name of Patient ________________________ Account #: __________________
Street Address: ________________________
City State Zip ________________________ Home Phone: __________________
Date of Birth: ________________________ Cell Phone: __________________
Social Security #: ________________ Work Phone: __________________
Race: Cirlce one Email: __________________
American Indian/Alaska Native
Asian
Black/African American
Not Hawaiian/Pacific Islander
Other Race
White

Marital Status: __________________
Sex: M F

Pharmacy Name: ______________________
Pharmacy Phone: ______________________

Ethnicity: Cirlce one Hispanic or Non Hispanic
Primary Language: ___________________________
Employer: ___________________________

RESPONSIBLE/INSURED PERSON INFORMATION

Name: ________________________________ Date of Birth: ________________________
Street Address: ________________________________ Social Security #:______________________
City, State and Zip ________________________________
Employer: ________________________________

	PRIMARY HEALTH INSURANCE	SECONDARY HEALTH INSURANCE
Insurance Name:	___________________________	___________________________
Group Name/Number:	___________________________	___________________________
Policy Number:	___________________________	___________________________
Policyholder Name:	___________________________	___________________________
Relationship: ________	1=self 2=Spouse 3=Dependent	________ 1=self 2=Spouse 3=Dependent
Copayment:	_________	_________
Referred by:	___________________________	___________________________

EMERGENCY CONTACT INFORMATION

Name: ___________________________________ Phone: ___________________

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; and some participating health insurance plans, I will be responsible for the full amount of the charges at the time of service.

Signature of Patient
Responsible Person ______________________________________ **Date:** ______________