Rivers to Wellness
PRIMARY CARE

Body Recomposition and Nutrition Program

Initial Patient Intake Questionnaire

MOTIVATION

What is your main reason for Obesity Treatment? (Check all that apply?)

- I want this for myself
- A Family Member insisted that I lose weight
- My physician recommended and referred me
- Other:

What is your motivation for Obesity Treatment? (Check all that apply?)

- To improve my appearance
- To be more active
- To have improved quality of life
- To improve or eliminate my obesity related health conditions
- Other:

What Treatments are you interested in pursuing? (Check all that apply?)

- Lifestyle change only (Diet and Exercise)
- Lifestyle and Anti-Obesity Medications
- Bariatric Surgery

WEIGHT HISTORY

Do you remember if you were a normal weight at birth?

Were you Obese in your childhood?

At what age do you remember being overweight or Obese?

- Highest Adult Weight?
- Lowest Adult Weight?
- Lowest Adult weight on a Diet or Weight loss Program?

Please describe when and how you started gaining weight?

Is there evidence of genetic history of Obesity (Check all that apply?)

- There is a strong family history of obesity
- Obesity started early and has been progressive during life
- I was excessively hungry as a child

DIET HISTORY

List all diets that have worked in the past:

Diet Name:	Amount Lost:	How long was the weight loss maintained?
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Have you ever consulted with a Registered Dietician?
Are you currently working with a Registered Dietician?

FOOD RECALL DIARY

Please Write down everything you ate in the last 24 hours

MEAL	TIME	Food and Drinks Consumed
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

DIETARY HABITS

Do you have excessive hunger 1-2 hours after having a regular meal?

Do you eat when you are not hungry? If so, when and why?

Do you eat for comfort when you are stress or emotional? If so, when and why?

Are there times that you eat and feel like you cannot stop? If so, when and why?

Do you ever try to manage your weight by vomiting, using laxatives, diuretics or excessive Exercise?
When was the last time this occurred?

Do you every find food on your bed that you do not remember eating?
How often does this happen?

Do you ever eat late at night or wake up in the night to eat?

PHYSICAL ACTIVITY

What type of work do you do? (check all that apply)

- At Work I am?
  - Constantly moving
  - Somewhat active
  - Not Active

Do you exercise regularly?

- What types of Exercise?
- How Often?
- How much time is spent in each exercise session?
- Have you ever weight lifted/performed resistance training?
- When was the last time you weight lifted?
- Did you do this in a gym or home?
- How many Steps per day on average do you walk?
- If you have not been able to exercise, Why?
- Do you enjoy physical activity?

Chronic Joint/Muscle and Injury History:

- Have you ever broken a bone, if so which one?
- How did you break your bone?
- Have you ever Injured your muscle or Joint, if so which one?
- How did you injure your muscle or Joint?
- Do you have any Chronic Joint Issues? If so describe.

SLEEP HISTORY

How many hours do you sleep per night?
What time do you go to bed on Weekdays?
What time do you wake up on weekdays?
What time do you go to bed on weekENDS?
What time do you wake up on WeekENDS?
How many times if any do you wake up in the middle of the night and why?

Have you ever Been Diagnosed with Sleep Apnea?
If Yes, Do you wear you CPAP at night?

STRESS/MENTAL HEALTH

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? (check that apply)	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
1. Little interest or pleasure in doing things	○ 0	○ 1	○ 2	○ 3
2. Feeling down, depressed, or hopeless	○ 0	○ 1	○ 2	○ 3
3. Trouble falling or staying asleep, or sleeping too much	○ 0	○ 1	○ 2	○ 3
4. Feeling tired or having little energy	○ 0	○ 1	○ 2	○ 3
5. Poor appetite or overeating	○ 0	○ 1	○ 2	○ 3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	○ 0	○ 1	○ 2	○ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	○ 0	○ 1	○ 2	○ 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	○ 0	○ 1	○ 2	○ 3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	○ 0	○ 1	○ 2	○ 3

10. If you checked off any problems on this questionnaire so far, how difficult have these problems made if for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
○ 0	○ 1	○ 2	○ 3

Alcohol Use Assessment

Do you drink Alcohol?

What type of alcohol do you drink?

How many Drinks per Day do you consume?

How many drinks per week do you consume?

AUDIT – SELF REPORT

Questions	**0**	**1**	**2**	**3**	**4**	**Score**
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
How often do you have 6 or more drinks on 1 occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you have started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often nor the last year have you needed to first drink in the morning to get yourself going after heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative, friend, doctor or other healthcare worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					TOTAL:	

Do you engage in narcotic use?

What type of narcotics do you take?

Who prescribes it?

How often do you take narcotics?

Questionnaire of Eating and Weight Patterns

1. During your lifetime, what has been your highest weight ever? _____ pounds
2. How many times approximately have you lost 20 pounds or more when you were sick and then gained it back?
    a. Never
    b. Once or twice
    c. 3-4 times
    d. 5 times or more
3. During the past 6 months, did you often eat within any 2-hours of a meal that most people would regarded as an unusually large amount of food? YES or NO

If no: Skip to question 7

4. During the times when you ate this way did you often feel you could not stop eating or control what or how much you are eating? Yes or no

If no: Skip to question 7

5. During the past 6 months, how often, on average, did you have times when you ate this way that is, large amounts of food plus the feeling that you are eating was out of control? (There may have been some weeks when it was not present–just average those in.)
    a. Less than 1 day a week
    b. 1 day a week
    c. 2 to 3 days a week
    d. 4 to 5 days a week
    e. Nearly every day
6. Did you usually have any of the following experiences during these occasions?
    a. Eating much more rapidly than usual? Yes or no
    b. Eating until you felt uncomfortably full? Yes or no
    c. Eating large amounts of food when you did not feel physically hungry? Yes or no
    d. Eating alone because you are embarrassed by how much you are eating? Yes or no
    e. Feeling disgusted with yourself, depressed or feeling very guilty after overeating? Yes or no
7. In general, during the past 6 months, how upset were you by overeating?
    a. Not at all
    b. Slightly
    c. Moderately
    d. Greatly
    e. Extremely
8. In general, during the past 6 months, how upset for you by the feeling that you could not stop eating or control what or how much you are eating?
    a. Not at all
    b. Slightly
    c. Moderately
    d. Greatly
    e. Extremely
9. During the past 6 months, how important has your weight or shape been and how you feel about or evaluate yourself as a person–as compared to other aspects of your life, such as how you do at work, as a parent, or how you get along with other people?
    a. Weight and shape were not very important

b. Weight and shape played a part in how you felt about yourself
c. Weight and shape were among the main things that affected how you felt about yourself
d. Weight and shape with the most important things that affected how you thought about yourself

10. During the past 3 months, do you ever make yourself vomit in order to avoid gaining weight after binge eating? Yes for now
    a. If yes: How often, on average was that?
        i. Less than once a week
        ii. Once a week
        iii. 2-3 times a week
        iv. 4-5 times a week
        v. More than 5 times a week
11. During the past 3 months, did you ever take more than twice the recommended dose of laxatives in order to avoid gaining weight after binge eating? Yes or no
    a. If yes: How often, on average was that?
        i. Less than once a week
        ii. Once a week
        iii. 2-3 times a week
        iv. 4-5 times a week
        v. More than 5 times a week
12. During the past 3 months, did you ever take more than twice the recommended dose of diuretics or water pills in order to avoid gaining weight after binge eating? Yes or no
    a. If yes: How often, on average was that?
        i. Less than once a week
        ii. Once a week
        iii. 2-3 times a week
        iv. 4-5 times a week
        v. More than 5 times a week
13. During the past 3 months, did you ever fast or not eat anything at all for at least 24 hours in order to avoid gaining weight after binge eating? Yes or no
    a. If yes: How often, on average was that?
        i. Less than once a week
        ii. Once a week
        iii. 2-3 times a week
        iv. 4-5 times a week
        v. More than 5 times a week
14. During the past 3 months, did you ever exercised for more than an hour specifically in order to avoid gaining weight after binge eating? Yes or no
    a. If yes: How often, on average was that?
        i. Less than once a week
        ii. Once a week
        iii. 2-3 times a week
        iv. 4-5 times a week
        v. More than 5 times a week
15. During the past 3 months did you ever take more than twice the recommended dose of a diet pill in order to avoid gaining weight after binge eating? Yes or no
    a. If yes: How often, on average was that?
        i. Less than once a week
        ii. Once a week
        iii. 2-3 times a week
        iv. 4-5 times a week

v. More than 5 times a week

Previous Use of Anti-Obesity Medications

Drug Name	Amount of Weight Loss Achieved	Side effects Encountered
Phentermine		
Metformin		
Topiramate (Topamax)		
Buproprion (Wellbutrin)		
Phentermine/Topiramate (Qsymia)		
Buproprion/Naltrexone (Contrave)		
Lorcaserin (Belviq)		
Liraglutide (Saxenda)		
Semaglutide (Wegovy/Ozempci)		
Tirzepatide (Mounjaro/Zepbound)		
Other:		

MEDICAL HISTORY (list other Conditions in blank Boxes)

Glaucoma	Radiation to the brain			
Palpitations	Pancreatitis			
High blood pressure	Diabetes			
Chest Pain	Heart Rhythm Problems			
Heart Attack	Sleep Apnea			
Heart Failure	HYPOthyroidism			
Headaches	Hyperthyroidism			
Kidney Stones	Cushings Disease			
Seizures				
Head Trauma				

Personal or Family History of Thyroid Cancer, if so, which kind?

<u>Female Patients Only:</u>

Date of Last Menstrual Cycle?

Current Birth Control Method?

Are you planning on become pregnant in the next 6 months?

FAMILY HISTORY

Please indicate what MEDICAL conditions your family had or have, including obesity

- Mother:
- Father:
- Siblings:

SURGICAL HISTORY

- Did you ever have Obesity related surgeries (Gastric Bypass, Gastric Sleeve, LapBand, or other?
- What was the starting weight before the procedure?
- What was the lowest weight after the procedure?
- What symptoms did you have after the procedure related to the surgery?
- What other Surgeries have you had?

CURRENT PRESCRIBED MEDICATIONS:

Please List all medications that you are currently taking, Doses and Frequency?

Drug Name:	Dose:	Frequency?
Drug Name:	Dose:	Frequency?
Drug Name:	Dose:	Frequency?
Drug Name:	Dose:	Frequency?
Drug Name:	Dose:	Frequency?
Drug Name:	Dose:	Frequency?
Drug Name:	Dose:	Frequency?

Please list all Over-the Counter Medications that you take, how often and reason?

Drug Name:	Dose:	Frequency?
Drug Name:	Dose:	Frequency?
Drug Name:	Dose:	Frequency?
Drug Name:	Dose:	Frequency?
Drug Name:	Dose:	Frequency?
Drug Name:	Dose:	Frequency?
Drug Name:	Dose:	Frequency?

Do you take any of the following Medications? Circle all that apply

Carbamazepine	Gabapentin	Pregabalin	Valproate	Vigabatrin	Phenelzine
Nortriptyline	Amitriptyline	doxepin	Imipramine	Paroxetine	Citalopram
Escitalopram	mirtazapine	Thioridazine	olanzapine	Risperidone	Clozapine
Quetiapine	Haloperidol	Aripiprazole	Insulin	Glipizide	Pioglitazone
Repaglinide	Oral Steroids	Lithium	Oral Contraception		Cyproheptadine
Terazosin	Propranolol	Benadryl	Hydroxyzine	Cetirizine	Fexofenadine
Metoprolol	Atenolol	Venlafaxine			

Home Environment Assessment:

- Who else at home is suffering from Obesity?
    - Spouse:
    - Children:
    - Other:
- How will your family support you through this process?
- Who prepares your meals at home?
- Do you prepare meals for more than just yourself?
- Do you go out to Eat? If so
    - Where do you go out to eat?