MultiCare

Center for Weight Loss & Wellness

MultiCare Intake Questionnaire

General Information

Name_____ Age_____ Today's Date _____

Date of Birth _____ Email _____

Address _____ City _____ State _____ Zip _____

Phone (Home)_____ (Cell) _____ (Work) _____

Genetic Background: ❑ African American ❑ Hispanic ❑ Mediterranean ❑ Asian
❑ Native American ❑ Caucasian ❑ Northern European
❑ Other _____

When, where and from whom did you last receive medical or health care? _____

_____

Emergency Contact: _____ Relationship _____

Phone (Home)_____ (Cell) _____ (Work) _____

How did you hear about our practice?

❑ Referral from PCP ❑ MultiCare website ❑ Referral from specialist ❑ Referral from friend/family memb
❑ Social media ❑ Other _____

Current Health Concerns

Please rank current and ongoing health concerns in order of priority

Describe Problem Severity	Mild	Moderate	Severe	Prior Treatment/Approach Success	Excellent	Good	Fair
Example: Post Nasal Drip	*X*			*Elimination Diet*	*X*		
1.							
2.							
3.							
4.							
5.							
7.							
8.							
9.							
10.							
11.							

Current Prescription and Over the Counter Medications

Medication	Dosage	Start Date (mo/yr)	Reason for Use

Current Prescription and Over the Counter Medications *(cont.)*

Medication	Dosage	Start Date (mo/yr)	Reason for Use

Nutritional supplements (vitamins/minerals/herbs, etc.)

Name and Brand	Dosage	Start Date (mo/yr)	Reason for Use

Have medications or supplements ever caused unusual side effects or problems? ❑ Yes ❑ No

If yes, describe: _____

Allergies to Medications/Supplements/Food

Name of Medication/Supplement/Food:	Reaction:
1.	
2.	
3.	
4.	
5.	

Previous Surgeries

Type of Surgery:	Date:
1.	
2.	
3.	
4.	
5.	

Lifestyle Review

Sleep

How many hours of sleep do you get each night on average? _____

Do you have problems falling asleep? ❑ Yes ❑ No Staying asleep? ❑ Yes ❑ No

Do you have problems with insomnia? ❑ Yes ❑ No Do you snore? ❑ Yes ❑ No

Do you feel rested upon awakening? ❑ Yes ❑ No

Do you use sleeping aids? ❑ Yes ❑ No

If yes, explain: _____

How do you rate your sleep? *(1 being the worst and 10 being the best)*

1 2 3 4 5 6 7 8 9 10

Exercise

Current Exercise Program:

Activity	Type	# of Times Per Week	Time/Duration (Minutes)
Cardio/Aerobic			
Strength/Resistance			
Flexibility/Stretching			
Balance			
Sports/Leisure (e.g., golf)			
Other:			

Do you feel motivated to exercise? ☐ Yes ☐ A little ☐ No

Are there any problems that limit exercise? ☐ Yes ☐ No

If yes, explain: _____

Do you feel unusually fatigued or sore after exercise? ☐ Yes ☐ No

If yes, explain: _____

How do you rate your exercise? *(1 being the worst and 10 being the best)*

1 2 3 4 5 6 7 8 9 10

Nutrition

Do you currently follow any of the following special diets or nutritional programs? *(Check all that apply)*

❑ Vegetarian ❑ Vegan ❑ Allergy ❑ Elimination ❑ Low Fat ❑ Low Carb ❑ High Protein
❑ Blood Type ❑ Low sodium ❑ No Dairy ❑ No Wheat ❑ Gluten Free
❑ Other: _____

Do you have sensitivities to certain foods? ❑ Yes ❑ No

If yes, list food and symptoms: _____

Do you have an aversion to certain foods? ❑ Yes ❑ No

If yes, explain: _____

Do you adversely react to: *(Check all that apply)*

❑ Monosodium glutamate (MSG) ❑ Artificial sweeteners ❑ Garlic/onion ❑ Cheese ❑ Citrus foods
❑ Chocolate ❑ Alcohol ❑ Red wine ❑ Sulfite–containing foods (wine, dried fruit, salad bars)
❑ Preservatives ❑ Food colorings ❑ Other food substances: _____

Are there any foods that you crave or binge on? ❑ Yes ❑ No

If yes, what foods? _____

Do you eat 3 meals a day? ❑ Yes ❑ No If no, how many _____

Does skipping a meal greatly affect you? ❑ Yes ❑ No

How many meals do you eat out per week? ❑ 0–1 ❑ 1–3 ❑ 3–5 ❑ >5 meals per week

How do you rate your nutrition? *(1 being the worst and 10 being the best)*

1 2 3 4 5 6 7 8 9 10

Diet

Please record what you eat in a typical day:

Breakfast_____

Lunch _____

Dinner _____

Snacks_____

Fluids_____

How many servings do you eat in a typical week of these foods:

Fruits (not juice)_____ Vegetables (not including white potatoes) _____
Legumes (beans, peas, etc)_____ Red meat _____ Fish _____
Dairy/Alternatives _____ Nuts & Seeds _____ Fats & Oils _____
Cans of soda (regular or diet)_____ Sweets (candy, cookies, cake, ice cream, etc.) _____

Do you drink caffeinated beverges? ❑ Yes ❑ No If yes, check amounts:

Coffee (cups per day) ❑ 1 ❑ 2-4 ❑ >4 Tea (cups per day) ❑ 1 ❑ 2-4 ❑ >4
Caffeinated sodas–regular or diet (cans per day) ❑ 1 ❑ 2-4 ❑ >4

Do you have adverse reactions to caffeine? ❑ Yes ❑ No
If yes, explain: _____

When you drink caffeine do you feel: ❑ Irritable or wired ❑ Aches or pains

How often do you cook?

I never cook 1 2 3 4 5 6 7 8 9 10 I love to cook

Smoking

Do you smoke currently? ❑ Yes ❑ No Packs per day:_____ Number of years _____
What type? ❑ Cigarettes ❑ Smokeless ❑ Pipe ❑ Cigar ❑ E-Cig
Have you attempted to quit? ❑ Yes ❑ No
If yes, using what methods:_____

If you smoked previously: Packs per day: _____ Number of years _____
Are you regularly exposed to second-hand smoke? ❑ Yes ❑ No

Alcohol

How many alcoholic beverages do you drink in a week? *(1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits)*
❑ 1–3 ❑ 4–6 ❑ 7–10 ❑ >10 ❑ None

Previous alcohol intake? ❑ Yes (❑ Mild ❑ Moderate ❑ High) ❑ None

Have you ever had a problem with alcohol? ❑ Yes ❑ No
If yes, when? _____
Explain the problem: _____

Have you ever thought about getting help to control or stop your drinking? ❑ Yes ❑ No

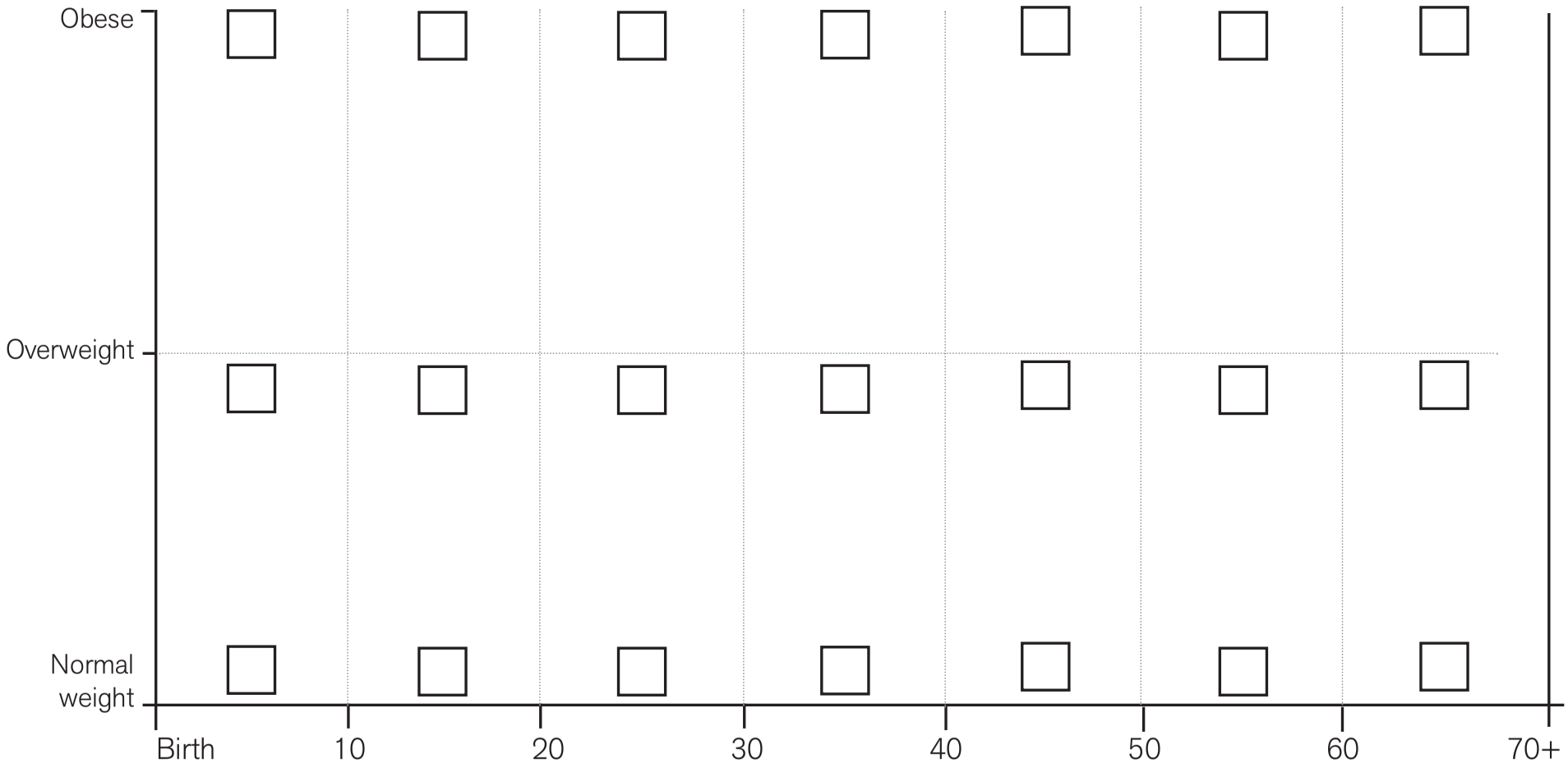
Other Substances

Are you currently using any recreational drugs? ❑ Yes ❑ No
If yes, type: _____

Have you ever used IV or inhaled recreational drugs? ❑ Yes ❑ No

Weight Graph

Please check the box at each age that best describes your recollection of your weight at that time.



Stress

Do you feel you have an excessive amount of stress in your life? ❑ Yes ❑ No

Do you feel you can easily handle the stress in your life? ❑ Yes ❑ No

How much stress do each of the following cause on a daily basis (Rate on scale of 1-10, 10 being highest)
Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____

Do you use relaxation techniques? ❑ Yes ❑ No
If yes, how often? _____

Which techniques do you use? (Check all that apply)
❑ Meditation ❑ Breathing ❑ Tai Chi ❑ Yoga ❑ Prayer ❑ Other: _____

Have you ever sought counseling? ❑ Yes ❑ No

Are you currently in therapy? ❑ Yes ❑ No
If yes, describe: _____

Have you ever been abused, a victim of crime, or experienced a significant trauma? ❑ Yes ❑ No

What are your hobbies or leisure activities? _____

Relationships

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Gay/Lesbian ❑ Long-Term Partner ❑ Widow/er

With whom do you live? (Include children, parents, relatives, friends, pets) _____

_____

Current occupation: _____ Shift: ❑ Day ❑ Swing ❑ Night ❑ Other

Previous occupations: _____

Do you have resources for emotional support? ❑ Yes ❑ No (Check all that apply)
❑ Spouse/Partner ❑ Family ❑ Friends ❑ Religious/Spiritual ❑ Pets ❑ Other: _____

Do you have a religious or spiritual practice? ❑ Yes ❑ No
If yes, what kind? _____

How well have things been going for you? (Mark on scale of 1–10, or N/A if not applicable)

	N/A	Poorly									Fine	Very Well
Overall	❑	1	2	3	4	5	6	7	8	9	10	
At school	❑	1	2	3	4	5	6	7	8	9	10	
In your job	❑	1	2	3	4	5	6	7	8	9	10	
In your social life	❑	1	2	3	4	5	6	7	8	9	10	
With close friends	❑	1	2	3	4	5	6	7	8	9	10	
With sex	❑	1	2	3	4	5	6	7	8	9	10	
With your attitude	❑	1	2	3	4	5	6	7	8	9	10	
With your boyfriend/girlfriend	❑	1	2	3	4	5	6	7	8	9	10	
With your children	❑	1	2	3	4	5	6	7	8	9	10	
With your parents	❑	1	2	3	4	5	6	7	8	9	10	
With your spouse	❑	1	2	3	4	5	6	7	8	9	10	

Readiness Assessment and Health Goals

Check that box that best describes where you see yourself in terms of readiness to change with regards to Weight loss, Diet and Exercise.

Weight Loss

- ❑ Pre contemplative *(Not even considering change.)*
- ❑ Contemplative *(Deciding if its worth the effort. Not yet actively making changes.)*
- ❑ Preparatory *(Preparing to experiment with small changes.)*
- ❑ Action *(Making active changes.)*
- ❑ Maintenance *(Changes have been made and I am working on maintaining the changes.)*

Diet

- ❑ Pre contemplative *(Not even considering change.)*
- ❑ Contemplative *(Deciding if its worth the effort. Not yet actively making changes.)*
- ❑ Preparatory *(Preparing to experiment with small changes.)*
- ❑ Action *(Making active changes.)*
- ❑ Maintenance *(Changes have been made and I am working on maintaining the changes.)*

Exercise

- ❑ Pre contemplative *(Not even considering change.)*
- ❑ Contemplative *(Deciding if its worth the effort. Not yet actively making changes.)*
- ❑ Preparatory *(Preparing to experiment with small changes.)*
- ❑ Action *(Making active changes.)*
- ❑ Maintenance *(Changes have been made and I am working on maintaining the changes.)*

Health Goals

What do you hope to achieve in your visit with us? _____

_____

_____

When was the last time you felt well? _____

_____

_____

Did something trigger your change in health? _____

_____

_____

What makes you feel better? _____

_____

_____

What makes you feel worse? _____

_____

_____

What do you feel needs to happen for you to get better? _____

_____

_____

Patient Identification - Write in or attach patient label

Name:

MRN#:

CSN#:

Age/Sex:

MULTICARE INTAKE QUESTIONNAIRE

MultiCare

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