Welcome to Sage Integrative Medicine

Please complete the questions below so we may serve you better.
We respect the confidential nature of this information, and will not release it without your permission, or as required by law. Thank you.

Date: _____

Initial Health Information for Resiliency Training or Weight Management Program

Name (Last, First, MI) _____
Date of Birth _____/_____/_____ Height: _____ Weight: _____ Age _____ Gender: ☐ F ☐ M
Phone: _____ Cell Phone: _____ Email: _____
Best means of contacting you: ☐ Phone ☐ Cell phone ☐ Email
Primary Care Provider: _____ Office phone: _____
May we contact your primary care provider? Yes / No Office fax: _____
How did you hear about our weight management program and/or Dr. Roemmelt?
_____

Do you understand your Patient Rights? Yes / No

History of Weight Patterns:

When did you first become overweight? (your age then) _____ (year)_____
How did your weight gain start? Please describe the circumstances: _____
_____
What do you think is the cause of your weight gain? _____
_____
What was your highest weight? (excluding pregnancy)_____Your age then?_____# of years ago? ___
What was your lowest weight? _____Your age then?_____# of years ago? ____
Have you ever stayed the same weight for 10 years or more? Yes / No
What was your approximate weight at age 18 years old _____, 5 years ago _____
Have you attempted to lose weight before? ____ most lbs lost: ____ how long did it take? _____
How long were you able to maintain your lower weight? _____
Describe previous methods of weight loss (e.g. diets, pills., injections, hypnosis, acupuncture) and describe your results: (please feel free to add additional input on a separate page)
_____
_____
_____
If you overeat, where and when do you do most of your overeating?
_____
Can you walk up a flight of stairs without stopping? (12 stairs) Yes / No
How far can you walk without stopping? _____
Do you have any difficulties putting on your shoes and socks? Yes / No
Any difficulties performing your personal hygiene routines? Yes / No
Do you have any difficulties performing necessary household chores/activities? Yes / No
Do you feel uncomfortable in a theater/airplane seat? Yes / No
Is there anything you can't do because of your weight? _____
Do you feel you suffer from low self esteem or negative body image related to your current weight? Y / N

What is motivating you to seek weight loss now?

_____

On a scale of 1 to 10, how ready are you to make lifestyle changes to assist with weight loss? _____
On a scale of 1 to 10, how confident are you that you will be successful losing weight? _____
What potential obstacles do you foresee in addressing the lifestyle changes that may be undermining your health and in adhering to the therapeutic protocols which we will co-create here?

_____

_____

What may be some ways you might explore to address these obstacles?

_____

Who will support you in this transformational process?

_____

Please make any additional comments that you think might be helpful:

_____

_____

Dietary / Nutritional History:

Approximately how many full meals do you eat a day? _____
How often do you snack between meals eat day? _____ none _____1-2 times _____ >3 times
Do you skip meals? Yes / No Which meals? _____ How often? _____
Do you do your own grocery shopping? Yes / No
Who does the cooking at your house? _____
Do you eat out? Yes / No How often? _____ Where? _____
What time of day are you usually most hungry?
_____Morning _____ Afternoon _____ Evening _____Late night
What meal of the day is the largest?

_____

Do you often have cravings for sugary or other types of foods throughout the day? Which ones?

_____

Please list any special diet guidelines or restrictions that you follow: (example: vegan or gluten-free)

_____

Do you have any food allergies or food intolerances? (Please list these foods)

_____

_____

How many times each day do you eat the following foods?:

Starches (bread, bagel, cereal, oats, pasta, rice, potato) ☐ never ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ 9-11 ☐ >11
Fruits ☐ Never ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ >8
Vegetables ☐ Never ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ 9-11 ☐ >11
Legumes (beans or lentils) ☐ Never ☐ 1-2 ☐ 3-5 ☐ >5
Seeds or Nuts ☐ Never ☐ 1-2 ☐ 3-5 ☐ >5
Dairy (milk, yogurt, cheese): ☐ Never ☐ 1-2 ☐ 3-5 ☐ >5
Meat, fish, poultry, eggs ☐ Never ☐ 1-2 ☐ 3-5 ☐ >5
Fats (butter, margarine, mayo, oil, salad dressing, sour cream, cream cheese) ☐ Never ☐ 1-2 ☐ 3-5 ☐ >5
Sweets (candy, cake, juice) ☐ Never ☐ 1-2 ☐ 3-5 ☐ >5
Do you drink water regularly? _____If yes, how many cups? _____
Do you drink coffee regularly? _____ If yes, how many cups? _____ do you add cream(er) or sugar? Y / N

Do you drink soda regularly? _____ If yes, how many cans/cups a day? _____
Have you ever been treated for an eating disorder? Yes / No If yes, which one(s):
_____

Activity History:

How often do you exercise?
☐ never or rarely ☐ 1-2 days per week ☐ 3-5 days per week ☐ 6-7 days per week
How long is your exercise activity per session?
☐ None ☐ <30 minutes ☐ 30-60 minutes ☐ 1 hour ☐ > 1 hour
What intensity is your exercise activity?
☐ light ☐ moderate ☐ moderate-vigorous ☐ vigorous
What type of exercise do you do regularly? (select all that apply)
☐ walking ☐ jogging/running ☐ weight training ☐ bicycling ☐ yoga ☐ Tai Chi or qigong ☐ dancing
other: _____

Stress:

How would you describe your general stress level?
☐ low stress ☐ moderate stress ☐ high stress
Please describe any current emotional or life stressors:
_____
How do you relax?
_____
Do you have a meditation practice or relaxation technique?
_____
What brings you joy and are you most grateful for in your life?
_____
Do you have any pets? _____
Please list your hobbies/creative endeavours :
_____
Are there any religious, cultural or spiritual needs pertinent to your treatment ☐ Yes ☐ No
If yes, please describe: _____

Sleep History:

How many hours of sleep do you usually get per night? _____
Do you have difficulty with: ☐ falling asleep ☐ staying asleep ☐ arising ☐ snoring ☐ restless legs
How do you feel mostly throughout the day? ☐ tired and fatigued ☐ energetic and alert
Do you wake up with a headache? Yes / No sore throat? Yes / No

What is the chance you would doze off when you are:

Sitting and reading?	☐ never	☐ slight	☐ moderate	☐ high	
Watching TV?	☐ never	☐ slight	☐ moderate	☐ high	
Sitting inactive in a public place, like a theater or meeting?	☐ never	☐ slight	☐ moderate	☐ high	
A passenger in a car?	☐ never	☐ slight	☐ moderate	☐ high	
Lying down to rest in the afternoon?	☐ never	☐ slight	☐ moderate	☐ high	
Sitting quietly after lunch?	☐ never	☐ slight	☐ moderate	☐ high	
In a car, stopped in traffic?	☐ never	☐ slight	☐ moderate	☐ high	/21

Patient Name _____ Date of birth: ____/ _____/ _____

Past Medical History

Please check any of the following conditions you have now or have had in the past:

Now	Past	Now	Past	Now	Past
☐	☐ **Anemia**	☐	☐ **Eye/visual problem**	☐	☐ **Memory problems**
☐	☐ **Anxiety/panic**	☐	☐ **Fainting**	☐	☐ **Multiple Sclerosis**
☐	☐ **Arthritis**	☐	☐ **Fibromyalgia**	☐	☐ **Muscle, bone, joint injury**
☐	☐ **Asthma**	☐	☐ **Fractures**	☐	☐ **Neck Aches**
☐	☐ **Backaches**	☐	☐ **Glaucoma**	☐	☐ **Nervous system disorder**
☐	☐ **Breast issues**	☐	☐ **Gout**	☐	☐ **Numbness/tingling**
☐	☐ **Bipolar disorder**	☐	☐ **Headaches**	☐	☐ **Osteoporosis**
☐	☐ **Blood clots**	☐	☐ **Heart disease/MI**	☐	☐ **Pacemaker/ implants**
☐	☐ **Cancer**	☐	☐ **Heart murmur**	☐	☐ **Parkinson's Disease**
☐	☐ **Chronic Fatigue**	☐	☐ **Hernia**	☐	☐ **Prostate disease**
☐	☐ **Chronic wounds**	☐	☐**High blood pressure**	☐	☐ **Restless leg syndrome**
☐	☐ **Circulatory problem**	☐	☐ **High cholesterol**	☐	☐ **Rheumatic fever**
☐	☐ **Concussion/ TBI**	☐	☐ **HIV**	☐	☐ **Seizure**
☐	☐ **Constipation**	☐	☐ **Immune issue**	☐	☐ **Sinus trouble**
☐	☐ **Depression**	☐	☐ **Incontinence**	☐	☐ **Skin disorder**
☐	☐ **Diabetes**	☐	☐ **Irregular heartbeat**	☐	☐ **Sleep disturbance**
☐	☐ **Diarrhea**	☐	☐ **Kidney disease**	☐	☐ **Sleep apnea**
☐	☐ **Digestion issues**	☐	☐ **Kidney stones**	☐	☐ **Stroke**
☐	☐ **Dizziness**	☐	☐ **Liver disease**	☐	☐ **Thyroid disease**
☐	☐ **Ear/Hearing issue**	☐	☐ **Low blood pressure**	☐	☐ **Urinary tract infections**
☐	☐ **Edema**	☐	☐ **Low libido**	☐	☐ **Valvular disorder**
☐	☐ **Emphysema/COPD**	☐	☐ **Lung disease**	☐	☐ **Varicose Veins**
☐	☐ **Erectile issues**	☐	☐ **Lyme disease**	☐	☐ **Other** _____

Reproductive History (for women):

Is your menstrual cycle regular? Yes / No If no, how is your cycle irregular?_____

Are you currently on an oral birth control pill? Yes / No Other form of contraceptive? _____

Number of pregnancies: _____ Number of miscarriages:_____

Have you had infertility issues? Yes / No If yes, what?_____

Any history of gestational diabetes? Yes / No Any other complications in pregnancy? _____

Are you pregnant now or actively attempting to become pregnant? Yes / No

Have you reached menopause? Yes / No If yes, what age? _____

Are you taking hormone replacement therapy? Yes / No If yes, what?_____

Please list any previous surgeries with the dates:

_____

_____

_____

Are you allergic to medications? Please list with reaction you experienced: _____

Allergy to Latex? Yes / No

Other allergies/sensitivities: _____

Patient Name _____ Date of birth: ____/ _____/ _____

Please list any medications/vitamins/supplements/herbal products that you are currently taking, with their doses: (please attach additional sheets if necessary)

_____
_____
_____
_____
_____

Health Care Maintenance:
If you have had any of the following services, please write down the most recent date of the service
Comprehensive physical exam: _____ Breast exam: _____ Mammogram: _____
GYN/PAP smear: _____ Testicular exam: _____ Prostate exam: _____
Colonoscopy: _____ Bone density: _____ Tetanus immunization: _____
Pneumonia vaccine: _____ Shingles vaccine: _____ Other recent immunizations:
_____

Social History:

Is English your primary language? Yes / No If no, what is your primary language?_____

Work: ☐ Employed, Fulltime or Parttime ☐ Unemployed ☐ Retired ☐ Disabled
Current Occupation: _____ Former Occupation: _____
Does your job involve prolonged: Sitting Heavy Lifting Walking Repetitive Motions Overnight Shift Work

Highest level of education attained: _____
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner
Do you live alone? Yes / No If no, with whom do you live? _____

How many drinks of alcohol do you average daily? _____ Weekly?_____
Do you use recreational drugs, i.e. marijuana, cocaine, stimulants? Yes / No
In the last year have you ever drunk alcohol or used drugs more than you meant to? Yes / No
In the last year, have you ever felt you wanted, or needed, to cut down on drinking or drug use? Yes / No

Have you smoked, or do you smoke or chew tobacco of any kind? Yes / No
If yes, how much? _____ How long? _____ Have you quit? Yes / No
If not, would you like assistance in quitting? Yes / No

Family History:

Name: **Age:** **(If deceased, please list cause of death and age)** **Medical Issues:**
Mother: _____
Father: _____
Sister(s): _____
Brother(s): _____
Partner/ Spouse: _____
Children: _____

Patient Name _____ Date of birth: ____/ _____/ _____

Please list any other medical information of significance, or anything else that might have a bearing on your health:

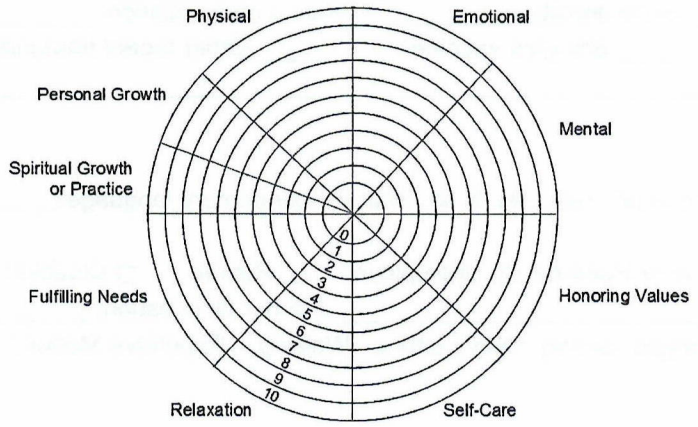
_____

_____

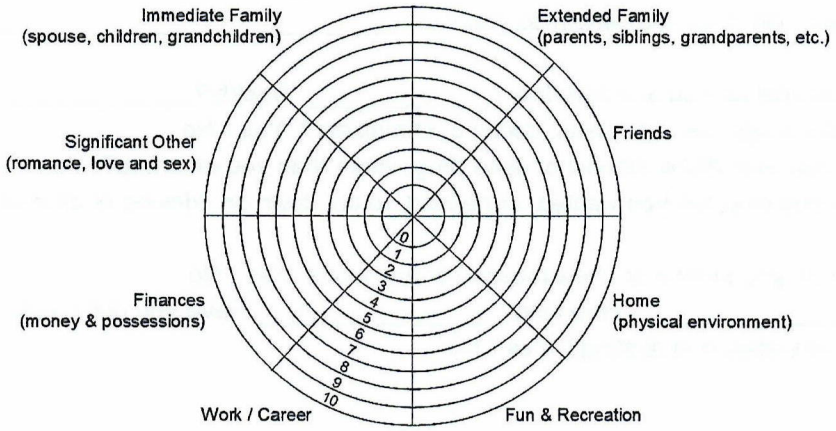
_____

Wellness is a balance of many factors. Using the circle below, please shade in your level of `satisfaction in each area as it relates to you.
For example, if you are extremely happy in your practice of relaxation, shade the entire pie shape for relaxation. Do the same for each area, starting from the center point radiating outwards.

Health Wheel for Creating Balance



Wheel of Life for Creating Balance



Thank you for taking the time to complete this form.
We look forward to providing you the best possible care.

Patient History completed by:_____

Signature: _____ Date: _____

Address: _____

Reviewed by: _____ Date_____