GENESIS Health Solutions
WHERE HEALTH BEGINS

Date: ____/____/_____

Health Assessment

First Name: _____ Last Name:_____
Address:_____
City: _____ State: _____ Zip Code: _____
Phone: _____Phone (Home/Work): _____Occupation:_____
Date of Birth: ___/___/_____ Age: _____ Sex: _____ Race: _____
Email Address (Please Print) _____

Current Height: _____ Weight: _____ Weight 1 Year Ago: _____
Lowest Adult Weight: _____ At what Age? _____ How long maintained? _____
Lowest Adult Weight Maintained for > 1 year_____ At what age? _____
Married? _____ Spouse's Name:_____
Do you have any Children? _____ If so, how many and what ages?_____

What is your personal goal weight? _____lbs
How many times have you intentionally lost 20lbs or more and gained it all back?
Never ____ Once or twice _____ 3-4 Times _____ 5+ Times _____

How did you hear about us?
TV:_____ Internet:_____ Newspaper:_____ Radio:_____

If someone referred you, who may we thank? _____

Check all that Apply:

☐ I eat when I am not hungry.	☐ I can over eat almost any food.
☐ I sometime eat much faster and/or much more than others.	☐ I graze or snack frequently between meals
☐ I isolate from others so I can eat the way I want.	☐ I am obsessive about the way I think about food.
☐ I sometimes think I will Eat moderately and then eat much more than I expected to eat.	☐ I think weight causes me serious physical and social problems and I still overeat
☐ I use food to numb difficult feelings	☐ I have tried to stop binging and been unable to stay stopped

Weight loss can be complex. If you have failed in the past, it could be because you have some of the following. Please check all that apply.

☐ Fatigue
☐ Difficulty getting to sleep
☐ Difficulty staying asleep
☐ High amounts of stress
☐ Over heating
☐ Cold hands and feet
☐ Low sex drive
☐ Abdominal Pain
☐ Diarrhea
☐ Constipation
☐ Gas after a meal
☐ Frequent Urination
☐ Sugar Cravings
☐ Irritable if meals are missed
☐ Fatigue after meals
☐ Fibromyalgia
☐ Depression
☐ Mental fatigue
☐ Menopause
☐ Muscle pain
☐ Joint pain
☐ Back pain
☐ Knee pain
☐ Hip pain
☐ Take pain medication

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Please make a **P** for in the past or a **C** for currently have. Please leave blank if the condition does not apply:

Condition	Past or Current	Condition	Past or Current	Condition	Past or Current
Cancer (Active)		Asthma		Irregular Heartbeat	
Diabetes		Anemia		Phlebitis	
Kidney Disease (Dialysis) ESRD		Chest Pain		Low Back Pain	
Severe Depression		Chronic Diarrhea		Epilepsy	
Celiac		Constipation		Seizures	
Heart Disease		Fainting		Shortness of Breath	
Liver Disease		Frequent Headaches		Sleep Difficulties	
Kidney Disease (Non-Dialysis)		Frequent Nausea		Stroke	
		Gallbladder Disease		Swelling of Feet	
Cancer (Previously)		Gout		Thyroid Disease	
High Blood Pressure		Heartburn		Ulcers	
High Cholesterol		Dizziness		Yellowing	
Lap band		Arthritis		Hemorrhoids	
Gastric Bypass		Alcoholism/Drug Abuse		Allergies	
Anxiety/Panic Attacks		Mild Depression		Neuropathy	

For Women Only: Please check ALL that Currently Apply

Do you have an IUD		**Do you take Birth Control**		**Hormone Replacement Therapy**	
E-sure		**Use any other form of Birth Control**		**Are you Pregnant or Planning to be Pregnant (next 6 months)**	
PCOS		**Full Hysterectomy**		**Partial Hysterectomy**	

Do you still menstruate regularly? _____Yes _____No
If No, When did you Stop Menstruating and Why?_____

Medical Diagnosis: (Have you ever been diagnosed with Anything?)

Year	Reason

Current Medications: List all-- Including Name, Frequency, and Dose (Include hormones and birth control pills.)

Name of Medication	Dose	Frequency		Name of Medication	Dose	Frequency

Please List Any Food Allergies:

1. _____
2. _____

Previous Weight Loss Plans or Surgeries:

_____

_____

Do you Smoke Cigarettes? _____(Y/N) If Yes, # per day _____ For how long? _____
Do you Drink Alcohol? _____ (Y/N) If yes, How Much/Quantity per Week? _____
Have you ever participated in Counseling or Psychotherapy? (Y/N)_____
If yes, Whom_____
Type: Individual: _____ Family _____ Couples_____ Substance abuse _____

Primary Care Physician:
Full Name: _____
Address: _____
Phone Number: _____

Additional Care Provider(s)
Full Name: _____
Address: _____
Phone Number: _____

Consent to Contact PCP or Other Health Care Providers:

_____ _____
Sign Date