

WEIGHT LOSS

Medical Weight Loss Intake

A complete picture lets us build a safe, evidence-based plan with you.

Patient Information

PATIENT NAME (LAST, FIRST) _____

DATE OF BIRTH _____

TODAY'S DATE _____

CURRENT HEIGHT _____

CURRENT WEIGHT _____

CALCULATED BMI _____

WAIST CIRCUMFERENCE _____

GOAL WEIGHT _____

WHY THIS GOAL MATTERS TO YOU _____

Weight History

HIGHEST ADULT WEIGHT (LBS / AGE) _____

LOWEST ADULT WEIGHT (LBS / AGE) _____

WEIGHT 1 YEAR AGO _____

WEIGHT 5 YEARS AGO _____

AGE WHEN WEIGHT BECAME A CONCERN _____

LIFE EVENTS LINKED TO WEIGHT CHANGE (PREGNANCY, INJURY, MEDICATION, STRESS, ETC.) _____

Prior Weight Loss Attempts — Check all you've tried

 Commercial program (Weight Watchers, Noom) Self-directed dieting (calorie counting, etc.) Low-carb / keto Intermittent fasting Mediterranean diet Plant-based / vegetarian Meal replacement shakes Personal trainer / structured exercise Prescription weight loss medication (specify below) OTC supplements / herbal products Bariatric surgery (specify below) Therapy / counseling for eating None of the above

MOST WEIGHT EVER LOST & HOW (PROGRAM, DURATION, YEAR) _____

WHAT WORKED / DIDN'T WORK _____

PRIOR WEIGHT-LOSS MEDICATIONS TRIED (DRUG, DOSE, RESULT, WHY STOPPED) _____

BARIATRIC SURGERY (TYPE, YEAR, RESULT) _____

Why Now?

WHAT CHANGED THAT BROUGHT YOU IN TODAY? _____

Active Medical Conditions — Check all that apply

- | | | |
|--|---|--|
| <input type="checkbox"/> Type 2 diabetes | <input type="checkbox"/> Pre-diabetes | <input type="checkbox"/> Type 1 diabetes |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Fatty liver / NAFLD |
| <input type="checkbox"/> Sleep apnea (CPAP: <input type="checkbox"/> Y <input type="checkbox"/> N) | <input type="checkbox"/> PCOS | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Heart disease / heart attack | <input type="checkbox"/> Stroke / TIA | <input type="checkbox"/> Atrial fibrillation |
| <input type="checkbox"/> Asthma / COPD | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Acid reflux / GERD |
| <input type="checkbox"/> Joint pain / arthritis | <input type="checkbox"/> Depression / anxiety | <input type="checkbox"/> None of the above |

GLP-1 ELIGIBILITY — CRITICAL TO DISCLOSE

These conditions may affect whether GLP-1 medications (Wegovy®, Zepbound®, Ozempic®, others) are safe for you. **Please answer honestly.**

- | | |
|---|--|
| <input type="checkbox"/> Personal history of medullary thyroid cancer (MTC) | <input type="checkbox"/> Family history of MTC (parent, sibling, child) |
| <input type="checkbox"/> Multiple Endocrine Neoplasia syndrome type 2 (MEN 2) | <input type="checkbox"/> History of pancreatitis (acute or chronic) |
| <input type="checkbox"/> Gallbladder disease / gallstones | <input type="checkbox"/> Severe gastroparesis / chronic GI motility issues |
| <input type="checkbox"/> Diabetic retinopathy | <input type="checkbox"/> Pregnancy or actively trying to conceive |
| <input type="checkbox"/> Breastfeeding | <input type="checkbox"/> Suicide attempt or active suicidal ideation |
| <input type="checkbox"/> Eating disorder (anorexia, bulimia, binge eating) | <input type="checkbox"/> None of the above |

Surgeries & Hospitalizations

Procedure / Reason	Year	Where

Current Medications & Supplements

Include prescription, OTC, supplements, and birth control. Bring bottles to your visit if possible.

Medication / Supplement	Dose	How Often	Why

Allergies

DRUG / FOOD / ENVIRONMENTAL ALLERGIES AND REACTIONS

NO ALLERGIES
 None

Family History (Weight & Metabolic)

Condition	Mother	Father	Sibling	Grandparent
Obesity / significant weight issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type 2 diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease (before 55 M / 65 F)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medullary thyroid cancer / MEN 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Eating Patterns

MEALS PER DAY _____ **SNACKS PER DAY** _____ **LARGEST MEAL OF THE DAY**
 Breakfast Lunch
 Dinner

TYPICAL BREAKFAST _____ **TYPICAL LUNCH** _____ **TYPICAL DINNER** _____

TYPICAL SNACKS / LATE-NIGHT EATING _____ **MEALS AWAY FROM HOME PER WEEK** _____ **FAST FOOD PER WEEK** _____

Eating Behaviors — Check all that apply

- | | |
|---|---|
| <input type="checkbox"/> Eating when stressed or emotional | <input type="checkbox"/> Eating when bored |
| <input type="checkbox"/> Eating quickly / not feeling full | <input type="checkbox"/> Cravings for sweets |
| <input type="checkbox"/> Cravings for salty / crunchy foods | <input type="checkbox"/> Cravings for carbs |
| <input type="checkbox"/> Nighttime eating | <input type="checkbox"/> Binge eating episodes |
| <input type="checkbox"/> Restriction / skipping meals then overeating | <input type="checkbox"/> Hiding food / secretive eating |

Beverages

WATER PER DAY (OZ/CUPS) _____ **COFFEE / CAFFEINE PER DAY** _____ **SODA / SUGARY DRINKS PER DAY** _____ **DIET SODA PER DAY** _____

ALCOHOLIC DRINKS PER WEEK _____ **TYPE (BEER, WINE, LIQUOR, MIXED)** _____

Physical Activity

DAYS/WEEK OF EXERCISE _____ **MINUTES PER SESSION** _____ **TYPE (WALKING, GYM, SWIM, ETC.)** _____

ACTIVITY LEVEL AT WORK Sedentary (desk) Moderate (on feet) Heavy / physical

BARRIERS TO EXERCISE Time Access Pain / injury Motivation

Sleep & Stress

AVG HOURS OF SLEEP / NIGHT _____ **SLEEP QUALITY (1-10)** _____ **CURRENT STRESS LEVEL (1-10)** _____ **SNORE LOUDLY / PAUSE BREATHING?**
 Yes No
 Unsure

Goals & Readiness

WHAT DOES SUCCESS LOOK LIKE IN 6 MONTHS?

WHAT DOES SUCCESS LOOK LIKE IN 12 MONTHS?

ON A SCALE OF 1-10, HOW READY ARE YOU TO MAKE CHANGES?

HOW CONFIDENT ARE YOU THAT YOU CAN SUCCEED? (1-10)

WHAT'S YOUR BIGGEST WORRY ABOUT THIS PROCESS?

Treatment Preferences

Your provider will discuss what's safe and appropriate for you. This helps us understand your preferences.

- | | |
|---|---|
| <input type="checkbox"/> Open to GLP-1 medications (Wegovy®, Zepbound®, others) | <input type="checkbox"/> Prefer to start with lifestyle changes only |
| <input type="checkbox"/> Want to combine medication with lifestyle coaching | <input type="checkbox"/> Interested in nutrition support / meal planning |
| <input type="checkbox"/> Interested in behavioral / mental health support | <input type="checkbox"/> Comfortable with self-injection (weekly) |
| <input type="checkbox"/> Need help with injection training | <input type="checkbox"/> Open to compounded alternatives if covered options unavailable |

Insurance & Cost Awareness

HAVE YOU TRIED TO GET GLP-1 COVERED BEFORE?

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Yes — approved | <input type="checkbox"/> Yes — denied |
| <input type="checkbox"/> Never tried | |

INSURANCE CARRIER

MONTHLY OUT-OF-POCKET BUDGET YOU CAN SUSTAIN

OPEN TO SELF-PAY IF NOT COVERED?

- | | |
|--|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Depends on cost | |

Lab & Monitoring Acknowledgment

WHAT TO EXPECT

- Baseline labs before starting medication: CMP, lipid panel, HbA1c, TSH, lipase (and others as indicated)
- Follow-up labs typically at 3 and 6 months, then periodically
- Monthly weight check + blood pressure during titration
- Visits every 4–6 weeks while titrating the dose, then less frequently
- Side effect monitoring (GI symptoms, gallbladder, pancreatitis warning signs)

Patient Acknowledgment

I have answered the questions on this intake truthfully. I understand that withholding information about my medical history or current medications may make weight-loss treatment unsafe for me. I understand that medical weight loss requires a combination of medication (when prescribed), lifestyle changes, and regular monitoring, and that results vary between individuals. I will notify Rocket City Clinics promptly of any new medications, medical conditions, pregnancy, or side effects.

PATIENT SIGNATURE

DATE