CORAL GABLES
EXECUTIVE PHYSICIANS
INTERNAL MEDICINE

550 Biltmore Way · Suite 101
Coral Gables, FL 33134
Phone 305.446.9940 · facsimile 305.446.0861

Weight Loss Intake Form

In order to lose weight, how willing are you to:

	very willing 5	4	3	2	1 not willing at all
Significantly modify your diet	❑	❑	❑	❑	❑
Take several nutritional supplements each day	❑	❑	❑	❑	❑
Take meal replacement products once daily	❑	❑	❑	❑	❑
Take prescription medications each day	❑	❑	❑	❑	❑
Modify your lifestyle (e.g., work, demands, sleep habits)	❑	❑	❑	❑	❑
Engage in regular high intensity exercise	❑	❑	❑	❑	❑
Engage in regular moderate intensity exercise	❑	❑	❑	❑	❑

Comments: _____

_____

_____

At the present time, how supportive do you think the people in your household will be to your implementing the above changes?	very supportive 5	4	3	2	1 very unsupportive
	❑	❑	❑	❑	❑

Comments: _____

_____

_____

3 Day Diet Diary Instructions

It is important to keep an accurate record of your usual food and beverage intake as part of your treatment plan. Please complete this diet diary for 3 consecutive days including one weekend day. Do not change your eating behavior at this time as the purpose of this food record is to analyze your present eating habits. Record information as soon as possible after the food has been consumed. Describe the food or beverage as accurately as possible e.g., milk what kind? (whole, 2%, nonfat); toast - (whole wheat, white , buttered); chicken - (fried, baked, breaded) coffee - (decaffeinated with sugar and ½ & ½). Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, etc. Include any additional comments about your eating habits on this form (ex. Craving sweet, skipped meal and why, when the meal was at a restaurant, etc).

Diet Diary

Day 1: Food Type Amount consumed

Eating habits:

Day 2: Food Type Amount consumed

Eating habits:

Day 3: Food Type Amount consumed

Eating habits:

Nutrition History

Have you ever had nutrition consultation? ❑ Yes ❑ No

Have you made any changes in your eating habits because of your health? ❑ Yes ❑ No
If yes, please describe: _____

_____

_____

Do you currently follow a special diet or nutritional program? ❑ Yes ❑ No
Check all that apply:

- ❑ Low Fat
- ❑ Low Carbohydrate
- ❑ High Protein
- ❑ Low Sodium
- ❑ Diabetic
- ❑ No Dairy
- ❑ No Wheat
- ❑ Gluten Restricted
- ❑ Vegetarian
- ❑ Vegan
- ❑ Ultrametabolism
- ❑ Atkins
- ❑ South Beach Diet
- ❑ Mediterranean Diet
- ❑ Specific program for weight loss/maintenance type
- ❑ Paleo
- ❑ other

Do you avoid any particular foods? ❑ Yes ❑ No
If yes, type and reason: _____

_____

_____

If you could only eat a few foods a week, what would they be?

_____

_____

Do you grocery shop? ❑ Yes ❑ No
If not, who does the shopping?

_____

_____

Do you read food labels? ❑ Yes ❑ No

Do you cook? ❑ Yes ❑ No
If not, who does the cooking ?

_____

_____

How many meals do you eat per day?

_____

_____

How many snacks?

_____

_____

Check all the factors that apply to your current lifestyle and eating habits:

- ❑ Fast eater
- ❑ Erratic eating pattern
- ❑ Eat too much
- ❑ Late night eating
- ❑ Dislike healthy food
- ❑ Time constraints
- ❑ Eat more than 50% of meals away from home
- ❑ Travel frequently
- ❑ Non-availability of health foods
- ❑ Do not plan meals or menus
- ❑ Reliance on convenience items
- ❑ Poor snack choices
- ❑ Significant other or family members don't like healthy foods
- ❑ Significant other or family members have special diatery needs or food preferences
- ❑ Love to eat
- ❑ Eat because I have to
- ❑ Have a negative relationship to food
- ❑ Struggle with eating issues
- ❑ Emotional eater (eat when sad, lonely, depressed, bored)
- ❑ Eat too much under stress
- ❑ Eat too little under stress
- ❑ Don't care to cook
- ❑ Eating in the middle of the night
- ❑ Confused about nutrition advice

The most important thing I should change about my diet to improve my health is:

_____

_____

_____

_____

Smoking:

Currently smoking? ❑ Yes ❑ No

How many years? _____ Packs per day: _____ Attempts to quit: _____

Previous Smoker: How many years? _____ Packs per day: _____

2nd hand smoke exposure? ❑ Yes ❑ No

Alcohol Intake:

How many drinks currently per week? (1 drink = 5 ounces wine, 12 oz beer, 1.5 ounces spirits)

_____

Other substances:

Caffeine intake? ❑ Yes ❑ No

Cups/day coffee; tea ❑ 1 ❑ 2-4 ❑ >4 a day

Soda or diet soda intake? ❑ Yes ❑ No

How many servings daily?

_____

Exercise:

Current exercise program: activity (list type, number of sessions / week, and duration of activity)

Activity type:	Frequency per week:	Duration in minutes:
Stretching		
Cardio/Aerobics		
Strength		
Other (yoga, pilates, gyrotonics, etc)		
Sport or Leisure Activities (golf, tennis, rollerblading, etc.)		

List any problems that limit activity: _____

Do you feel unusually fatigued after exercise? ❑ Yes ❑ No

If yes, please describe: _____

Sleep / Rest:

Average number of hours you sleep per night?

Food:

Do you have known adverse food reaction or sensitivities? ❑ Yes ❑ No

If yes, describe symptom: _____

Do you have any food allergies or sensitivities? ❑ Yes ❑ No

If yes, list all: _____