

# PROGRAM INTAKE FORM

## SCULPTD Life

706 9TH St SW, Calgary, AB

236-900-3111 (clinic)

info@sculptd.ca

www.SCULPTD.ca

Full Name : \_\_\_\_\_

Date Of Birth : \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Gender :  Male  Female  Other

Address : \_\_\_\_\_  
\_\_\_\_\_

Phone Number : \_\_\_\_\_ E-Mail : \_\_\_\_\_

Family Doctor : \_\_\_\_\_ Phone Number : \_\_\_\_\_

PHN : \_\_\_\_\_

Insurance : \_\_\_\_\_ Policy Number : \_\_\_\_\_

*Check all that apply*

### MEDICAL HISTORY

- |  |   |
|--|---|
| <input type="checkbox"/> Anemia                        | <input type="checkbox"/> Kidney Disease             |
| <input type="checkbox"/> Arthritis                     | <input type="checkbox"/> Kidney Stones              |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Liver Disease/Hepatitis    |
| <input type="checkbox"/> Bipolar Affective Disorder    | <input type="checkbox"/> Pneumonia                  |
| <input type="checkbox"/> Blood Clots/Bleeding disorder | <input type="checkbox"/> Pancreatitis               |
| <input type="checkbox"/> Cancer                        | <input type="checkbox"/> Polyps                     |
| <input type="checkbox"/> COPD/Chronic Bronchitis       | <input type="checkbox"/> Polycystic Ovarian         |
| <input type="checkbox"/> Chronic Diarrhea              | <input type="checkbox"/> Schizophrenia              |
| <input type="checkbox"/> Type 1 Diabetes               | <input type="checkbox"/> Sleep Apnea                |
| <input type="checkbox"/> Type 2 Diabetes               | <input type="checkbox"/> Stomach Ulcers             |
| <input type="checkbox"/> Depression                    | <input type="checkbox"/> Skin Disease               |
| <input type="checkbox"/> Heart Disease                 | <input type="checkbox"/> Valvular Heart Disease     |
| <input type="checkbox"/> High Blood Cholesterol        | <input type="checkbox"/> Addiction to drugs/alcohol |
| <input type="checkbox"/> High Blood Pressure           | <input type="checkbox"/> Epilepsy or Seizures       |
| <input type="checkbox"/> Hypothyroidism                | <input type="checkbox"/> Gallstones                 |

## MEDICAL HISTORY

List all meds you are currently taking (include vitamins/supplements/over the counter)

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List all previous surgeries

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Have you ever been hospitalized for reasons other than surgeries? If yes, list reasons:

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List any allergies you have:

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Have you ever seen a therapist? Yes/No

When/reason: \_\_\_\_\_

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## LIFESTYLE HISTORY

Smoking No/Yes.

If Yes, \_\_\_cigs/day for \_\_\_ years

Alcohol No/Yes.

If Yes, \_\_\_ drinks/day for \_\_\_ years

Drug use : No/ Yes.

If Yes, (specify) \_\_\_\_\_

Work hours:

Occupation:

Married? Y/N

Kids? Y/N (ages)

## NUTRITION HISTORY

What factors are a concern for you that impact your weight and health?

Factors	Yes	No	Factors	Yes	No
Eating too often			Shift work		
Unhealthy food choices			No time to cook/make meals		
Night time eating			No energy to do housework or shopping		
Large portions at meals			Stress from work/family		
Liquid calories (pop, juice, etc)			I'm not as active as I want to be		
No time to be active			Hard to follow a program or plan		
Craving certain foods			Frustrated with lack of results		
Hunger			Not feeling full		
Problems chewing or swallowing			Other_____		

Can you see a direct link between eating and emotional events in your life? Yes/No

Do any of these feelings trigger overeating? (check all that apply)

- Depression or feeling down
- Celebration or happiness
- Losing control (can't stop)
- Social/habit
- Feeling very hungry
- Chronic pain
- Boredom     Reward.     Anxiety     Stress

**PHYSICAL ACTIVITY**

Do you do any physical activity?  No, only my daily routines.  Yes, (specify)

Type of Activity	Time	How often	Intensity

Do you have limitations to exercise? If so, what are they?

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How many hours per day do you sit? \_\_\_\_

Is there anyone in your family with weight issues? Who? \_\_\_\_\_

How many hours do you sleep per night? \_\_\_\_\_

Do you have a regular sleep schedule? \_\_\_\_\_

Do you feel rested every morning? \_\_\_\_\_

Do you have any sleep issues (insomnia, sleep apnea, etc)? \_\_\_\_\_

Are you interested in medications to assist with weight loss? Yes/No/ Undecided

Have you previously been prescribed medications for weight loss? If so, which ones?

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**END OF QUESTIONNAIRE**