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The hCG Weight Loss Protocol Intake

Date: _____

Patient Name: _____ **Date of Birth:** _____ **Sex:** __**F** __ **M**

Are you currently attempting to get pregnant? Yes No

Pregnant? Yes No **Breastfeeding?** Yes No

Family History (circle all that apply):

Cancer Diabetes Heart Disease/Heart Attack High Blood Pressure Kidney Disease Liver Disease Obesity

Stroke Gout Depression Other: _____

All Past Surgeries you have had and approximate month/year of the surgeries:

_____

_____

_____

Any Medical Conditions you currently are being treated for or your doctor is considering treating you for:

_____

_____

_____

List all Medications and Supplements you are currently taking or should be taking:

_____

_____

_____

List all medication and food allergies:

_____

_____

_____

Do you smoke? Yes No

Patient Name:_____

Do you drink alcohol? Yes No **If so** (circle one): Daily Occasionally Rarely

Weight History:

Most you have weighed _____

Least you have weighed as an adult? _____

What you weigh now_____

Over the past year have you (Circle One):

Gained Weight Lost Weight Maintained Weight

Goal Weight _____

Is there a particular event you are preparing for? Yes No

If so what is the event and when is it?_____

What diets have you followed in the past?_____

Do you drink sodas of any kind? Yes No If so: Occasionally or Daily

Do you eat breakfast? Yes No

Do you skip meals? Yes No

When are you the hungriest in your typical day? _____

Do you eat out/purchase your meals more than 3 times a week? Yes No

If so how many days a week? _____

What are your favorite foods?

_____

_____

What are your least favorite foods?

_____

_____

What is your favorite meat?_____ **Vegetable?**_____ **Fruit?**_____ **Drink?**_____

Approximately how much water do you drink each day? _____

Patient Name:_____

Are you an emotional eater? Yes No

Do you binge eat? Yes No

Your Daily activity Level (circle one): Sedentary 1 2 3 4 5 6 7 8 9 10 Very Active

Do you Exercise (circle one): Once a week 2 to 3 times a week 3 to 4 times a week More than 5 times a week

Physical Activity (circle one):

Cardio Exercise Strength Training No exercise at all

Do you have a physical condition that limits your exercise activity? Yes No

If so what is that limitation?

_____

_____

General Wellness:

Stress Level (circle one): Total relaxation 1 2 3 4 5 6 7 8 9 10 Suicidal

What is your primary motivation for weight loss?

_____

_____

How motivated are you now compared to previous attempts to lose weight?

_____

_____

Why do you feel you have had difficulties losing weight?

_____

_____

Why do you feel you have had difficulties keeping the weight off?

_____

_____