Hello. Welcome to LWmed.

This Global Assessment Questionnaire has been developed by LWmed to begin the process of getting to know you and your individualized needs. We will review this Questionnaire with you at your appointment.

Please take the time to thoroughly fill out this Questionnaire prior to your Global Assessment Appointment.

First Name _____ Last Name _____

Mailing Address _____ City/State _____ Zip _____

Phone _____ Alternate phone _____

Date of Birth _____ Age _____ Email address _____

Do you use social media? YES / NO If YES, which networks/handles: _____

_____

Your preferred method(s) of communication? (circle all that apply)

NO PREFERENCE CALL TEXT EMAIL SOCIAL MEDIA OTHER (specify): _____

Primary Care Physician

Name of physician and clinic: _____ Phone #: _____

Mental Health Provider and Additional Health Care Providers

Name of provider and clinic: _____ Phone #: _____

Name of provider and clinic: _____ Phone #: _____

Emergency Contact

Name: _____ Phone #: _____ Relationship: _____

Pharmacy Used for Prescription Medications

Name: _____ Phone #: _____

Health

How do you consider your overall health to be? (circle one)

POOR FAIR GOOD VERY GOOD EXCELLENT

Last Physical Exam. When was your last physical exam? _____

Fasting Labs. When did you last have fasting labs completed? _____

Pain. How much bodily pain do you commonly have? (circle one)

VERY SEVERE SEVERE MODERATE MILD VERY MILD NONE

Missed Work Days. How many days from work did you miss in the last 6 months due to illness or injury? _____

Trauma or Abuse. Have you experienced abuse or trauma (physical, emotional or sexual)? YES / NO

Medical Conditions. Have you had any of the following medical conditions? Circle all that apply.

High Blood Pressure	Asthma	Gallbladder Disease	Anemia
Heart Disease	Fainting/light headed	Liver Disease	Low back pain
Frequent Fatigue	Diabetes	Chest Pain	Gout
Thyroid Disease	High Cholesterol	Irregular Heartbeat	Ulcers
Kidney Disease	Chronic Cough	Alcoholism or Drug Abuse	Constipation
Shortness of Breath	Allergies	Arthritis	Diarrhea
Stroke	Depression	Cancer	Heartburn
Frequent Headaches	Anxiety or Panic Attacks	Dizziness	Frequent Nausea
Seizures or epilepsy	Other (please indicate):		

Current Medications and dosages: _____

_____

_____

Current Supplements: _____

_____

_____

Medication allergies: _____

_____

Exercise

Rate how important regular physical activity is to you: 1 (not important) - 10 (very important)

1 2 3 4 5 6 7 8 9 10

Regular physical activity. Do you currently participate in regular physical activity? YES / NO

Aerobic exercise. How many times per week do you engage in aerobic exercise like walking, cycling, jogging, swimming, aerobic dance, active sports? (Indicate activity and how often) _____

_____

Strength exercises. How many times per week do you do strength building exercises? _____

_____

Flexibility or stretching exercises. How many times per week do you do stretching exercises? _____

_____

Yoga. How many times per week do you do yoga? _____

Do you have any current limitations on physical activity like injuries, illness, medical or health conditions? _____

_____

_____

Interests: (please circle all that are interesting to you)

Yoga	Dance	Free weights	Tennis	Outdoor walk/jog
Pilates	Aerobics	Weight machines	Hiking	Competitive sports
Elliptical	Video tapes	Calisthenics	Group classes	Exercise Ball
Stationary bike	Swimming	Personal Training	Skiing	Resistance bands
Cycling outside	Seated exercises	Treadmill		

Other _____

_____

Sleep

Rate the general quality of your sleep: 1 (very poor sleep) - 10 (great sleep)

1 2 3 4 5 6 7 8 9 10

Trouble Falling Asleep. Do you have trouble falling asleep? YES / NO

Trouble Staying Asleep. Do you have trouble staying asleep? YES / NO

Hours per night. On average, how many hours do you sleep per night? _____

Snore. Do you snore loudly? YES / NO

Tiredness. Do you often feel tired, fatigued, or sleepy during the day? YES / NO

Respiratory Issues. Has anyone observed you to stop breathing or gasping during the night? YES / NO

Nutrition and Eating

What would you like to change about what and how you eat?_____

_____

_____

_____

When and what do you usually eat over the course of a typical day? (Write NONE if you do not eat that meal or snack)

Meal	**Time**	**Foods Eaten**
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

How many times do you graze/snack per day? _____

Do you eat right before going to bed? NEVER ALMOST NEVER SOMETIMES OFTEN VERY OFTEN

When you do, what do you eat? _____

How many ounces of water do you drink each day? _____

Who plans meals? _____ Who cooks? _____ Who grocery shops? _____

Which foods do you crave the most? _____

_____

Do you eat while watching TV? YES / NO

Screen Time. How much time/day do you spend on a computer, phone, tablet, tv, other devices? _____ hours

THE FOLLOWING QUESTIONS ASK ABOUT YOUR EATING PATTERNS AND BEHAVIORS WITHIN THE LAST 3 MONTHS. FOR EACH QUESTION, CHOOSE THE ANSWER THAT BEST APPLIES TO YOU.

1. During the last 3 months, did you have any episodes of excessive overeating (eating significantly more than most people would eat in a similar period of time? YES / NO

NOTE: IF YOU ANSWERED "NO" TO QUESTION 1, YOU MAY STOP AND GO TO THE NEXT PAGE

2. Do you feel distressed about your episodes of excessive overeating? YES / NO

3. During your episodes of excessive overeating, how often did you feel like you had no control over your eating (e.g., not being able to stop eating, feel compelled to eat, or going back and forth for more food)?

NEVER/RARELY SOMETIMES OFTEN ALWAYS

4. During your episodes of excessive overeating, how often did you continue eating even though you were not hungry?

NEVER/RARELY SOMETIMES OFTEN ALWAYS

5. During your episodes of excessive overeating, how often were you embarrassed by how much you ate?

NEVER/RARELY SOMETIMES OFTEN ALWAYS

6. During your episodes of excessive overeating, how often did you feel disgusted with yourself or guilty afterward?

NEVER/RARELY SOMETIMES OFTEN ALWAYS

7 . During the last 3 months, how often did you make yourself vomit as a means to control your weight or shape?

NEVER/RARELY SOMETIMES OFTEN ALWAYS

Tell Us More About You

Please list and tell us about weight loss experiences you've had in the past:

	What age were you	Pounds Lost	What/how/why do you think you lost weight at this particular time in your life
1.			
2.			
3.			

If you have been pregnant, please tell us about your weight experience during and after pregnancy: _____

_____

Have you attempted any of the following behaviors in order to prevent gaining weight?

Taking more than twice the recommended dose of diet pills	Y	N
Taking more than twice the recommended dose of laxatives	Y	N
Taking more than twice the recommended dose of diuretics	Y	N
Vomiting after eating	Y	N
Abstaining from food for more than 24 hours	Y	N
Exercising excessively	Y	N

Family History of Overweight. Tell us about family members that had or have overweight or obesity:

Relative	**Age**	**Degree of Overweight**			
		None	**Slight (5-15lbs)**	**Moderate (16-49 lbs)**	**Very (50+ lbs)**
Mother					
Father					

Weight Loss Medication. Have you used weight loss medication? YES / NO
If YES, which ones and what was your experience with them? _____

_____

Supportive. Are your friends or family supportive of your weight loss efforts? YES / NO If YES, please elaborate. If NO, go to the next question: _____

_____

Not Supportive. Is anyone likely to sabotage your efforts? YES / NO If YES, please elaborate. _____

_____

_____

Cigarettes. Do you smoke cigarettes? YES / NO If YES, how many per day: _____

Alcohol. Do you drink alcohol? YES / NO If YES, type and amount of alcohol per week: _____

_____

Relationship. What is your marital or relationship status? _____

Children. How many children do you have? What are their ages? _____

Free Time. What do you typically do in your free time? _____

_____

Education and Work. Your highest grade/college year/degree completed: _____ Your occupation: _____

What hours do you usually work? _____ How long have you been in this occupation? _____

Are you satisfied with your job/career? NOT AT ALL SLIGHTLY MODERATELY GREATLY EXTREMELY

Stress. Rate your stress level on a scale from 0 (no stress) - 10 (extreme stress): _____

Coping with Stress. How well do you feel you are coping with your current stress load? (Circle one)

UNABLE TO COPE NOT COPING WELL COPING FAIRLY WELL COPING VERY WELL

Source of Stress. What is the most significant source of your stress at this time? _____

_____

_____

Helpful with Stress. What have you found to help with this stress? _____

_____

PHQ-9

The following is an evidence-based screening tool called the PHQ-9 that might include questions you've answered elsewhere. Your answers here (again) are important:

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	Over half the days	Nearly every day
a. Little interest or pleasure in doing things	0	1	2	3
b. Feeling down, depressed or hopeless	0	1	2	3

NOTE: IF YOU ANSWERED "0" TO INDICATE "NOT AT ALL" TO QUESTION a AND b ABOVE, YOU MAY STOP AND GO TO THE NEXT PAGE.

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	Over half the days	Nearly every day
c. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
d. Feeling tired or having little energy	0	1	2	3
e. Poor appetite or overeating	0	1	2	3
f. Feeling bad about yourself…or that you are a failure or having let yourself or your family down	0	1	2	3
g. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
h. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
i. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

GAD-7

The following is another evidence-based screening tool called the GAD-7 that might include questions you've answered elsewhere. Your answers here (again) are important:

Over the last 2 weeks, how often have you been bothered by the following problems? (circle the number to indicate your answer)	Not at all	Several days	Over half the days	Nearly every day
a. Feeling nervous, anxious, or on edge	0	1	2	3
b. Not being able to stop or control worrying	0	1	2	3
c. Worrying too much about different things	0	1	2	3
d. Trouble relaxing	0	1	2	3
e. Being so restless that it's hard to sit still	0	1	2	3
f. Becoming easily annoyed or irritable	0	1	2	3
g. Feeling afraid as if something awful might happen	0	1	2	3

If you indicated any problems above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (circle one)

NOT DIFFICULT AT ALL SOMEWHAT DIFFICULT VERY DIFFICULT EXTREMELY DIFFICULT

What Else Would You Like to Tell Us?

Is there any additional information that would be helpful to us to know when developing your individualized lifestyle and weight management plan? _____