

Name: _____

Date of Birth: _____

Kirkpatrick Family Care
Christie Kirkpatrick Schmutz, MD
Weight Loss Medicine Intake Form

Welcome! I'm so glad you've taken the step to come talk with me about your weight and improve your health. Please take a few minutes to fill out the form below so I can understand your weight journey and how I can best help you reach your goals. We will talk more about this during your visit.

Weight History

What is your "best weight ever" (the weight at which you felt best/healthiest)? When was that?

What has triggered weight gain for you in the past? (having kids, menopause, stress, job changes, etc.)

What strategies have you tried to lose weight? (special diets, exercise plans, Weight Watchers, etc.)

What worked and what didn't?

Motivation

Why do you want to lose weight?

What are your greatest health concerns?

How are you limited by weight? (trouble keeping up with grandkids, walking in the grocery store, etc.)

On a scale of 1-10:

- How important to you is it to lose weight? _____
- How confident are you that you can succeed? _____
- How interested are you in making this change right now? _____

Nutrition

-Who does the cooking at home? _____

-Do you usually eat meals with others? If so, who? _____

-What does a typical day of eating look like for you (or, what did you eat in the last 24 hours)?

- Breakfast: _____

- Lunch: _____

- Dinner: _____

-Snacks: (include timing): _____

-How many sodas or sweet beverages do you drink in a week or a month? Diet or regular?

-How many times per week or month do you eat out at a restaurant or get take out?

-How many alcoholic beverages do you drink per week or month?

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-Do you usually eat because you are (circle all that apply) - stressed, looking for a treat, truly hungry, emotional

-Do you have any food allergies or intolerances? _____:

-Are there any foods you avoid for religious or ethical reasons? _____

-What foods do you really NOT like? _____

-What makes it hard for you to make healthy eating choices? (prices, family preferences, time, etc.)

Activity

-Do you intentionally exercise? Y / N If so, how many days per week? _____

-How many minutes per session of exercise? _____

-How active are you on a daily basis? Circle one: sitting most of the time, on feet some of the time, on feet most of the time

-Do you count your steps? Y / N If so, how many steps do you take per day? _____

-What type of exercise do you enjoy? _____

-What type of exercise do you hate? _____

-What makes it hard for you to exercise (time, access to a gym, energy, pain, etc.)

Past Medical History

Please circle all of the conditions that you currently have or have had in the past, and list any relevant details (timing, treatment, etc.) next to the condition.

Heart Attack, angina, or stroke

Diabetes

High blood pressure

Heart failure

Irregular heart rhythms (palpitations, a-fib etc).

Low thyroid or thyroid cancer

Family history of "MEN2" (rare genetic syndrome that includes adrenal, thyroid, and parathyroid cancers)

Depression or Anxiety

Alcohol addiction

Migraines

Chronic pain

Eating disorders

Liver disease including fatty liver disease or cirrhosis

Gallstones or other gallbladder issues

Pancreatitis

GERD or heartburn/reflux

Sleep apnea

Gout

Glaucoma

Kidney stones

Seizures

Arthritis or other joint pain

Women: Are you currently pregnant, breast feeding, or planning to become pregnant? Y / N

Women: What is your current method of birth control, if any? _____

Behaviors/Miscellaneous

- How many hours of sleep do you get per night? _____

- Do you snore or wake up feeling like you didn't rest well? Y / N

- Who do you consider your main support system? _____

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date _____ Patient Name: _____ Date of Birth: _____

**Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.**

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. 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
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these 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

**Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.**

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these 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

Binge Eating Disorder Screener (BEDS-7) Symptom Self-Assessment

For use with adults

This tool is intended for screening use only. It should not be used as a diagnostic tool. The following questions ask about your eating patterns and behaviours 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 (i.e., eating significantly more than what most people would eat in a similar period of time)?	YES	NO
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NOTE: IF YOU ANSWERED "NO" TO QUESTION 1, YOU MAY STOP. THE REMAINING QUESTIONS DO NOT APPLY TO YOU.

2. Do you feel distressed about your episodes of excessive overeating?	YES	NO
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Within the past 3 months...	Never or Rarely	Sometimes	Often	Always
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)?				
4. During your episodes of excessive overeating, how often did you continue eating even though you were not hungry?				
5. During your episodes of excessive overeating, how often were you embarrassed by how much you ate?				
6. During your episodes of excessive overeating, how often did you feel disgusted with yourself or guilty afterward?				
7. During the last 3 months, how often did you make yourself vomit as a means to control your weight or shape?				

Please share this screener with your healthcare team.



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PRMCDA/CA/LDX/0067 131992/01/2024-E



Adverse Childhood Experience Questionnaire for Adults

California Surgeon General's Clinical Advisory Committee



Our relationships and experiences—even those in childhood—can affect our health and well-being. Difficult childhood experiences are very common. Please tell us whether you have had any of the experiences listed below, as they may be affecting your health today or may affect your health in the future. This information will help you and your provider better understand how to work together to support your health and well-being.

<p>Instructions: Below is a list of 10 categories of Adverse Childhood Experiences (ACEs). From the list below, please place a checkmark next to each ACE category that you experienced prior to your 18th birthday. Then, please add up the number of categories of ACEs you experienced and put the <i>total number</i> at the bottom.</p>	
1. Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?	
2. Did you lose a parent through divorce, abandonment, death, or other reason?	
3. Did you live with anyone who was depressed, mentally ill, or attempted suicide?	
4. Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?	
5. Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?	
6. Did you live with anyone who went to jail or prison?	
7. Did a parent or adult in your home ever swear at you, insult you, or put you down?	
8. Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?	
9. Did you feel that no one in your family loved you or thought you were special?	
10. Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?	
<p>Your ACE score is the total number of checked responses</p>	

Do you believe that these experiences have affected your health? Not Much Some A Lot

Experiences in childhood are just one part of a person's life story.
There are many ways to heal throughout one's life.

Please let us know if you have questions about privacy or confidentiality.