Metabolic Fitness Program Intake Questionnaire

Please complete the following pages as completely and accurately as possible. Welcome and Thank you!

Medical Record Number _____

Date _____

PHQ-9 Over the last 2 weeks how often have you been bothered by any of the following problems:

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	◯	◯	◯	◯
Feeling down, depressed, or hopeless	◯	◯	◯	◯
Trouble falling asleep, staying asleep, or sleeping too much	◯	◯	◯	◯
Feeling tired or having little energy	◯	◯	◯	◯
Poor appetite or overeating	◯	◯	◯	◯
Feeling bad about yourself, feeling you are a failure, or feeling that you have let yourself or your family down	◯	◯	◯	◯
Trouble concentrating on things, such as, reading the newspaper or watching television	◯	◯	◯	◯
Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than normal	◯	◯	◯	◯
Thoughts that you would be better off dead or of hurting yourself in some way?	◯	◯	◯	◯

If you checked off any problem on this questionnaire so far, 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?

◯ Not difficult at all
◯ Somewhat difficult
◯ Very difficult
◯ Extremely difficult
◯ Unknown
◯ N/A

Drug Use

Do you currently use recreational drugs?

◯ No
◯ Yes

Alcohol Use

Do you drink alcoholic beverages?
- ◯ No
- ◯ Yes

If yes, how many drinks per week?
- ◯ Less than 1 per week
- ◯ 1-7 per week
- ◯ 7-14 per week
- ◯ Greater than 14 per week

Do you now, or have you ever had problems with excessive alcohol use?
- ◯ No
- ◯ Yes

If you drink more than an average of two alcoholic drinks each day, how ready (or motivated) are you to cut down or quit? (0=not ready, 5=somewhat ready, 10=very ready)

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ N/A

If you decided to cut down or quit drinking, how confident are you that you would succeed? (0=not ready, 5=somewhat ready, 10=very ready)

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ N/A

If you drink more than an average of two alcoholic drinks each day, what are the major obstacles to your cutting down or quitting?
- ☐ Do not see the need
- ☐ Enjoy alcohol
- ☐ Stress management
- ☐ Other
- ☐ N/A
- ☐ Unknown

If other, please specify: _____

Stress Management

On a scale from 0-10, how much stress would you say you have in your life? (0=no stress, 5=moderate stress, 10=very high amount of stress)

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ Unknown

What is your greatest source of stress?
- ☐ Family
- ☐ Health
- ☐ Work
- ☐ Finances
- ☐ Other
- ☐ Unknown

If other, please specify: _____

What do you presently do to manage your stress?
- ☐ Meditation
- ☐ Breathing Exercises
- ☐ Exercise
- ☐ Pray
- ☐ Talk
- ☐ Eat
- ☐ Read
- ☐ Watch television
- ☐ Substance Use (Alcohol, Tobacco, Drugs)
- ☐ Other
- ☐ No stress management technique
- ☐ Unknown

If other, please specify: _____

How ready (or motivated) are you to learn to decrease the stress and tension in your life? (0=not motivated, 5= somewhat motivated, 10=very motivated)

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ Unknown ◯ N/A

If you decided to decrease the stress and tension in your life, how confident are you that you would succeed? (0=not confident, 5=somewhat confident, 10=very confident)

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ Unknown ◯ N/A

What are the major obstacles to your reducing the amount of stress and tension in your life?

☐ Knowledge
☐ Work
☐ Family
☐ Finances
☐ Health
☐ Time Constraints
☐ Other
☐ Unknown
☐ N/A

If other, please specify: _____

Body Weight and Nutrition Information

Are you currently on a diet? ◯ No ◯ Yes

If yes, what specific diet are you following?

☐ Low Fat/Low Cholesterol
☐ Adkins
☐ South Beach
☐ Weight Watchers
☐ Low Carb
☐ Mediterranean
☐ Low Calorie
☐ Other

If other, please specify: _____

Weight History: How many times in your life have you intentionally lost the weight shown below?

5-10lbs (# times) _____

11-20lbs (# times) _____

21-30lbs (# times) _____

31-50lbs (# times) _____

51-100lbs (# times) _____

over 100lbs (# times) _____

How ready (or motivated) are you to make changes in your eating habits? (0=not ready, 5= somewhat ready, 10=very ready)

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ Unknown ◯ N/A

How confident are you that you will succeed in changing your eating habits? (0=not confident, 5= somewhat confident, 10=very confident)

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ Unknown ◯ N/A

What are the major obstacles to improving your diet?

☐ Emotional eating
☐ Difficulty sustaining desired eating patterns
☐ Lack of interest in changing eating patterns
☐ Lack of family support
☐ Lack of time and/or interest in cooking
☐ Financial
☐ Other
☐ Unknown
☐ N/A

If other, please specify: _____

Are you interested in trying partial meal replacement (over the counter or specialized medical food) as a tool to aid in weight loss?

◯ No ◯ Yes ◯ Maybe

Exercise History

Are you currently involved in a routine of regular aerobic exercise (moderate continuous exertion of at least 20 minutes 3 times per week)?

◯ No ◯ Yes

Are you currently involved in a muscle strengthening program?

◯ No ◯ Yes

If you are not exercising regularly, how ready are you to get started with a program of regular exercise? (0=not motivated, 5=somewhat motivated, 10=very motivated)

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ Unknown ◯ N/A

If you are not exercising regularly, what are the major obstacles to your starting?

☐ Cost
☐ Not Motivated
☐ Time Limitations
☐ Facilities/Equipment Available
☐ Physical Limitations
☐ Work Limitations
☐ Other
☐ N/A
☐ Unknown

If other, please specify: _____

OSA Screening

Have you been diagnosed with obstructive sleep apnea?	◯ No ◯ Yes ◯ Unknown
If yes, are you being treated with CPAP, BiPAP, or nighttime oxygen?	☐ CPAP ☐ BiPAP ☐ Nighttime Oxygen ☐ Unknown

STOP_BANG

	Yes	No
Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	◯	◯
Do you feel tired, fatigued, or sleepy during daytime?	◯	◯
Has anyone observed you stop breathing during your sleep?	◯	◯
Do you have or are you being treated for high blood pressure?	◯	◯