INFINITE HEALTH CENTERS

pH Test: _____

Name:_____ **Date:**_____

Current Weight:_____ **Desired Weight:** _____ **#Loss:** _____

How did you hear of Dr. deRoos? _____

Weight loss can be complex. Please check all that apply:

☐Fatigue	☐Gas after a meal	☐ Joint pain
☐Difficulty getting to sleep	☐Frequent Urination	☐Back pain
☐Difficulty staying asleep	☐Sugar Cravings	☐Knee pain
☐High amounts of stress	☐Irritable if meals are missed	☐Hip pain
☐Over heating	☐ Fatigue after meals	☐Take pain medication
☐Cold hands and feet	☐ Fibromyalgia	☐ Abdominal Pain
☐Low sex drive	☐Depression	☐Diarrhea
☐ Menopause	☐Mental fatigue	☐ Constipation

Please list any of the major health concerns in order of importance:
1. _____
2._____

Please list any food allergies:
1. _____
2._____

Previous Weight Loss Plans:
1._____
2. _____

Problem areas you would like addressed: (Please circle)

- Love handles
- Turkey Neck
- Cellulite
- Wrinkles/Age Spots
- Stretch Marks
- Flabby Arms
- Other Issues:

_____
_____

Please list all prior Surgeries and Year:

1._____
2_____
3. _____
4. _____
5. _____
6._____

Infinite Health Centers of Cleveland
340 Sunset Dr NW
Cleveland, TN 37312
(423)813-7575

Today's Date: _____

Health Assessment

First Name: _____ Last Name: _____
Address: _____ City:_____ ST:____ Zip:_____
Cell Phone:_____ Email:_____
Date of Birth: ___/___/___ Age: _____ Marital Status: _____

Height: _____ Weight: _____ Weight 1 Year Ago: _____
Lowest Adult Weight: _____ At what Age? _____ How long maintained? _____
What is your personal goal weight this time? _____
How many times have you intentionally lost 20 lbs. or more and gained it all back?
Never _____ Once or twice _____ 3-4 Times _____ 5+ Times _____

*Have you ever been diagnosed with an Eating Disorder? Yes or No? If yes, what type? _____

Do you exercise? Yes / No? Times per week? _____ Hours or mins per session?_____
How long have you been exercising? _____ What type of exercise do you do? _____

Check all that Apply:

☐ I eat when I am not hungry.	☐ I can over eat almost ANY food.
☐ I eat faster/more than others.	☐ I frequently snack between meals.
☐ I isolate from others to eat the way I want.	☐ I obsess about the way I think about food.
☐ I use food to numb difficult feelings.	☐ Weight causes me physical/social problems.
☐ I think I will eat moderately, and then overeat.	☐ I have tried to stop binge-eating.

List all current *medications*. (Include hormones and birth control pills.)

Name of Medication	Dose	Frequency		Name of Medication	Dose	Frequency

List all current *vitamins/minerals/supplements*.

Name of Supplement	Dose	Frequency		Name of Supplement	Dose	Frequency

Do you Smoke Cigarettes? _____(Y/N) If Yes, # per day _____ For how long? _____
Do you Drink Alcohol? _____ (Y/N) If Yes, How Much/Quantity per Week? _____
Have you ever participated in Counseling or Psychotherapy? (Y/N) _____
Type: Individual: _____ Family _____ Couples_____ Substance abuse _____

Check if you have or have had ANY of the following:

Condition	Check	Condition	Check	Condition	Check
Asthma		Arthritis		Pregnant/Nursing	
Anemia		Celiac		Kidney/Liver Disease	
Diabetes		Chest Pain		Cancer (Active)	
Irregular Heartbeat		Chronic Diarrhea		Cancer (Previously)	
Phlebitis		Chronic Constipation		Heart Disease	
Seizures		Fainting		Pacemaker	
Low Back Pain		Frequent Headaches		Autoimmune Disease	
Stroke		Frequent Nausea		Metal Pins/Plates	
Shortness of Breath		Allergies		HIV/AIDS	
Hemorrhoids		Gout		Thyroid Disease	
Neuropathy		Heartburn		Hepatitis C or D	
High Cholesterol		Dizziness		Gallbladder Disease	
Lap band		Mild Depression		High Blood Pressure	
Gastric Bypass		Severe Depression		Alcohol/Drug Abuse	
Anxiety/Panic Attacks		Serious Mental Disorder		Epilepsy	

For Women Only: Please check ALL that currently apply

☐ **Do you have an IUD**	☐ **Do you take Birth Control**	☐ **Hormone Replacement**
☐ **Essure**	☐ **Use any other form of Birth Control_____**	☐ **Are you Pregnant or Planning to be Pregnant (next 6 months)**
☐ **PCOS**	☐ **Full Hysterectomy**	☐ **Partial Hysterectomy**

Do you still menstruate regularly? _____Yes _____No
If No, When did you Stop Menstruating and Why?_____

Primary Care Physician:
Full Name: _____ Phone Number: _____
Address: _____

Additional Care Provider(s)
Full Name: _____ Phone Number: _____
Address: _____

Signature:_____ Date:_____