Wake Internal Medicine Consultants, Inc.

Intake Assessment Questionnaire

(Please complete prior to your appointment)

DEMOGRAPHIC DATA

Name:_____ DOB:_____ Sex: M F

Contact Number:_____

HEALTH HISTORY

1. Please circle if you have been diagnosed with any of the following:

Arthritis	Heart Attack or bypass Surgery
Asthma	Heart Disease/Atherosclerosis
Anxiety/Depression/Mood Disorder	Hyperlipidemia (High Cholesterol)
Cancer (type_____)	Hypertension (High blood pressure)
COPD/Emphysema	Kidney Disease
Diabetes	Liver Disease
Diabetic complications (kidney disease, eye problems, neuropathy, impotence)	Seizure Disorder
	Severe Head Injury/Trauma
	Sleep Apnea
GERD(acid reflux)	Stroke

2. What medical concerns, if any, do you have at the present time? _____
   _____

3. Do you smoke? Y N How much? _____ For how many years?_____

   Are you interested in quitting? Y N Are you a past smoker? Y N When did you quit?_____

4. Are you involved in physical activity? Y N How often you exercise?_____x/wk for _____min
   What types of exercise do you enjoy?_____

5. List all medications including over the counter drugs and supplements that you currently take.

SOCIOECONOMIC HISTORY

1. Are you employed? Y N Occupation:_____
2. Marital Status: Single Married Divorced Widowed Separated
3. Who prepares most of your meals?_____
4. Identify any support systems you have._____

DIET HISTORY

1. Do you follow any special diet, such as low cholesterol, kosher, vegetarian?_____
2. Do you have any food allergies or interolerances?_____
3. Are there any foods you do not like/are not willing to try?_____
   _____
4. What are you favorite foods?_____
   _____
5. Do you have any problems affording the foods you want to buy?
6. Do you drink alcohol? Y N How often?_____ Drinks per day/week
7. Have you ever tried to lose weight in the past? Y N

   What eating/diet plans have you tried? How much weight did you lose?_____
   - Weight Watchers
   - Meal Replacements
   - Jenny Craig
   - Low Calorie
   - Low Fat
   - Atkins/ South Beach
   - Nutrition Counseling
   - Low cholesterol
   - Diabetic Diet
   - Other (_____)
8. What changes would you like to make now? (circle all that apply)
   - Improve my eating habits
   - Improve activity levels
   - Lower blood pressure
   - Lose weight/Manage weight
   - Lower cholesterol
   - Lessen risk of diabetes
9. Would you prefer your eating plan to
   - Track portions/food groups
   - Count calories/grams
   - Make smarter food choices without counting calories or tracking everything I eat
10. Please add any additional comments you think may be helpful. _____
    _____
    _____

EDUCATIONAL INTERESTS

To tailor your eating plan to your needs, it is useful to know your desires/expectations. Please check one of the following to indicate the amount of structure you believe meets your needs:

a. Just tell me exactly what to eat for all my meals and snacks. I want a detailed food plan. Ex: ¾ c whole grain cereal, 1 c low fat milk, banana
b. I want a lot of structure but freedom to select foods. Ex. 1 milk, 1 starch, 1 fruit
c. I don't want an eating plan. I just want to eat better. I will just set food goals for each week. Ex: This week my goal is to add a serving of fruit to breakfast each morning.

What information would you like to review: (circle all that apply)

- Weight Management
- Healthy food preparation
- Fiber
- Reading labels
- Eating Out
- Portion Sizes
- Eating less fat
- Exercise Program
- Meal Planning
- Snack Foods

ALL DIABETIC PATIENTS PLEASE COMPLETE

1. What type of diabetes do you have? Type 1 Type 2 Don't Know
2. How long have you been a diabetic?_____
3. Have you ever had any diabetes education before?
4. Do you monitor blood glucose at home? Y N
   a. How often?___x/day or week
   b. When do you monitor? Fasting Pre-meal Post-meal Bedtime
   c. Do you record your results? Y N
   d. What is your ideal blood glucose?
      Fasting:_____ Pre-meal:____ Post-meal:____Bedtime:_____
5. In the last month have you had blood glucose over 250? Y N How often?_____
6. In the last month have you had blood glucose below 60? Y N How often?_____
7. Have you been hospitalized due to complications of diabetes? Y N
8. In the past year have you seen the Dentist? Y N Podiatrist? Y N Eye Doctor? Y N