


CONTEMPORARY ACUPUNCTURE


33 N. Waukegan Road, Suite 4
Lake Bluff, IL 60044

BARIATRIC ASSESSMENT FORM

Today's Date:				
PATIENT INFORMATION				
Last Name:		First:	Middle:	Marital Status:
Date of birth: / /		Age:	Gender:	Male Female
Social Security Number:			Email:	
Street Address:		Apt:	City:	State: Zip:
Home Phone:		Cell Phone:		Work Phone:
Occupation:		Employer:		Employer Phone Number:
In Case of Emergency, Contact:		Relationship:		Phone Number:
MEDICAL HISTORY				
Do you or any family member have history of:				
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No	
High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other				
CURRENT MEDICATIONS				
Please list all medications you are taking				
VISIT INFORMATION				
Are you interested in information regarding:				
Acupuncture	<input type="checkbox"/> Yes <input type="checkbox"/> No	AcuGraph Exam.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Organic Supplements	<input type="checkbox"/> Yes <input type="checkbox"/> No	Energy Adjustments	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Electro-Acupuncture	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herbal Formulas	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Homeopathy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Exercise Program	<input type="checkbox"/> Yes <input type="checkbox"/> No	
PLEASE CONTINUE ON PAGE 2 				

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WEIGHT HISTORY				
Height:	Current Weight:		Goal Weight:	
Heaviest Adult Weight:	When?	Lowest Adult:	When?	
Do you have a history of?				
Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No				
Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No				
WEIGHT LOSS PROGRAMS				
Weight Loss Program	Dates	Weight Loss	Weight Gain	Supervised
Weight Watchers				
Jenny Craig				
Slim Fast				
Special K				
Atkins				
Nutrisystem				
Hospital Based Program				
Diet Pills				
Other				
GENERAL NUTRITION HISTORY				
Do you currently exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If so, what is your routine?				
Do you have any food allergies/intolerances? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If so, please list:				
Do you take supplements/vitamins? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If so, please list:				
What would you like to achieve visiting this office?				
Do you see any barriers to achieving this goal?				
How often do you eat fast food?				
How often do you eat at restaurants?				
How often do you eat fried foods?				
How often do you eat desserts (cookies, cake, candy, etc)?				
PLEASE CONTINUE ON PAGE 3 				

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Please check the items you add to food:		
Butter <input type="checkbox"/> Yes <input type="checkbox"/> No	Margerine <input type="checkbox"/> Yes <input type="checkbox"/> No	Salad Dressing <input type="checkbox"/> Yes <input type="checkbox"/> No
Oil <input type="checkbox"/> Yes <input type="checkbox"/> No	Mayonnaise <input type="checkbox"/> Yes <input type="checkbox"/> No	Other
Please check the types of beverages you drink:		
Diet Soda/Tea <input type="checkbox"/> Yes <input type="checkbox"/> No	Water <input type="checkbox"/> Yes <input type="checkbox"/> No	Regular Soda/Tea <input type="checkbox"/> Yes <input type="checkbox"/> No
Energy Drink <input type="checkbox"/> Yes <input type="checkbox"/> No	Juice <input type="checkbox"/> Yes <input type="checkbox"/> No	Coffee <input type="checkbox"/> Yes <input type="checkbox"/> No
Ice Tea <input type="checkbox"/> Yes <input type="checkbox"/> No	Milk <input type="checkbox"/> Yes <input type="checkbox"/> No	Other
How often do you consume alcholic beverages?		
What type?		
What types of foods do you crave?		
Do you eat fresh fruits and vegetables? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you eat cheese/yougurt/milk on a daily basis? <input type="checkbox"/> Yes <input type="checkbox"/> No		
What is the first item you consume each day?		
Office Policy and Financial Responsibility		
Please read the following office policy. We would like for you to read and sign accordingly. Thank you for choosing "Contemporary Acupuncture".		
If you are not able to keep your appointment, please provide 1 (one) business day notice. Failure to provide appropriate notice will result in a standard fee for missed appointment. We understand that emergencies happen and will take into consideration before any charges are applied to your account.		
I have read the above policy.		
Patient's Name: _____		
Signature of patient: _____		
Date signed: ____/____/____		
"Contemporary Acupuncture" will make every attempt to ensure that you are seen in a timely manner.		
Your provider: Dr. Ricky J. Colmer, Ph.D., L.Ac		

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