# **Weekly Clinic Visit Questionnaire**

Name: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

1. Did you have any symptoms or physical problems since your last visit? Yes \_\_\_\_ No \_\_\_\_

If Yes, circle and comment: Light-headedness Headache Cramps Shortness of Breath Fatigue/Weakness Hair Loss Constipation Bruising/Bleeding Nausea/Vomiting Diarrhea Other

Comments:

1. Have you received any other medical care since your last visit? Yes \_\_\_\_ No \_\_\_\_ If Yes, who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason:

1. Any medications taken since your last visit? Yes \_\_\_\_ No \_\_\_\_ If Yes, what: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(New medications, dosage changes, stopped a medication)

1. Current program? (circle one) Essentials Optifast Individual

a. How many eating episodes (# of times you eat or have a meal replacement) per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Are you consuming a meal replacement liquid (protein shake)? Yes \_\_\_\_ No \_\_\_\_ What Formula? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, how many each day over the past week? Mon \_\_\_ Tues \_\_\_ Weds \_\_\_ Thurs \_\_\_ Fri \_\_\_ Sat \_\_\_ Sun \_\_\_

c. Are you consuming any nutritional bars (protein bars)? Yes \_\_\_\_ No \_\_\_\_ What brand? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, how many each day over the past week? Mon \_\_\_ Tues \_\_\_ Weds \_\_\_ Thurs \_\_\_ Fri \_\_\_ Sat \_\_\_ Sun \_\_\_

1. Did you drink at least 2 additional quarts of non-caloric fluid each day? Yes \_\_\_\_ No \_\_\_\_
2. Do you keep a food journal? Yes \_\_\_\_\_\_ No \_\_\_\_\_

If yes, how do you track yourself? \_\_\_\_ OnTrack or other electronic food journal \_\_\_\_handwritten

If yes, how many total calories did you consume over the past week?

Mon \_\_\_\_\_\_\_ Tues \_\_\_\_\_\_ Weds \_\_\_\_\_\_ Thurs \_\_\_\_\_\_ Fri \_\_\_\_\_ Sat \_\_\_\_\_\_ Sun \_\_\_\_\_\_

1. Did you participate in planned exercise this week? Yes \_\_\_\_No \_\_\_\_

How many days of strength training? \_\_\_\_ How many days of cardio? \_\_\_\_ Total minutes of cardio this week: \_\_\_\_\_

Average number of steps/day: \_\_\_\_\_\_\_\_\_\_\_\_

1. Did you attend a group class this week? Yes­\_\_\_\_\_\_ No\_\_\_\_\_\_\_
2. Are you interested in video visits? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_\_

1. Rate your adherence to the plan from 0 to 5: (not on plan at all) 0 1 2 3 4 5 (no deviations)

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL PROGRESS NOTES**

Weight \_\_\_\_\_\_\_\_\_Weight Change \_\_\_\_\_\_\_\_\_\_