HEALTH SCREENING QUESTIONNAIRE

TRILLIUM WEIGHT LOSS

PERSONAL HEALTH SCREENING

Contact information

Name: ____

Address: ______________________________ Apt: __________ City: ________________

Date of Birth: __________________ Age: _________ Sex: Male Female

Home Telephone: (____) ____________ Work or Cell Phone: (____) ________________

Medical History Screening:

Do you have a history of:

- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Depression
- ☐ ADHD
- ☐ Mental Illness (__________)
- ☐ Cancer (____________)
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Colitis
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ HIV / AIDS
- ☐ Frequent Infections
- ☐ Hormone Imbalances

Have you ever been institutionalized? Y ________ N ________ Approximate Date(s): ______________

Have you had any surgeries (recent or past): _______________ Approximate Date(s):______________

Do you have any binge eating tendencies/ habits? _______________ If so, how often? ____________

For women only:

Are you Pregnant: __ Yes ___ No Are you Nursing? ___ Yes ___ No Since how long? ___________

I, ______________________ affirm all the information on this form to be accurate and true to the best of my knowledge. I will not hold Trillium Weight Loss or any of their staff responsible for any of my errors or omission.

Date: _______________________ Client Signature: ______________________________________

ALL INFORMATION IS HELD IN THE STRICTEST CONFIDENCE. PLEASE COMPLETE THIS HEALTH SCREENING WITH AS MUCH DETAIL AND ACCURACY AS POSSIBLE AND RETURN IT TO THE TRILLIUM STAFF MEMBER.