Patient Weight Loss/Detoxification Questionnaire

If you want to lose weight, we can help you. We utilize a proven all-natural program called NuLean® that has helped thousands of people lose weight safely while also improving their health.

Since NuLean® is not just a weight-loss program, you should understand the theory behind the program may be different than any program you have tried in the past. Because of this, we strongly suggest you read the attached instructions carefully and visit nulean.com. These actions are vital to you receiving the most benefit from the program. Our goal is to improve your overall health as well as to enable you to shed pounds and inches and keep them off.

Patient Title: ☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Dr. ☐Prof. ☐Rev.				
First Name	**Nickname**	**Last Name**	**Middle Name**	**Suffix**
Address 1	**Address 2**	**City**	**State**	**Zip Code**
Primary Phone	**Secondary Phone**		**Mobile Phone**	
Home Email		**Work Email**		
Best Contact Method: (choose one) ☐ Primary Phone ☐Secondary Phone ☐Mobile Phone ☐Home Email ☐Work Email				

Date of Birth	Age	Gender	Marital Status	Occupation
		☐ Male ☐ Female ☐ Unspcfd	☐Single ☐Married ☐Other	

How did you hear about us? €Website €Newspaper €Phone book €Radio_____ € Referral _____

Stress

1. What is your daily stress level? 0 1 2 3 4 5 6 7 8 9 10
2. Have you ever sought help for a mental health issue? ☐No ☐Yes
3. Please mark any current stresses in your life:
☐Beginning/ending college ☐Children (birth, parenting issues, etc.) ☐Death of friend or relative ☐Financial difficulties
☐Moving ☐Relationships (marriage, divorce, end of relationship, etc.) ☐Work/job change ☐Other _____
4. Are you planning any major life changes in the next year? ☐No ☐Yes _____
5. What is your most significant source of stress at this time? _____

Sleeping

1. How many hours of sleep do you get per night? 0 1 2 3 4 5 6 7 8 9 10
2. What is your sleep quality? ☐Excellent ☐Good ☐Fair ☐Poor
3. How many times is your sleep interrupted per night? 0 1 2 3 4 5 6 7 8 9 10

Smoking Status

1. Do you currently smoke or chew tobacco of any kind? ☐Never ☐Former ☐Yes (cigarettes) ☐Yes (chew)
2. If yes, how often do you smoke or chew? ☐Everyday ☐Somedays
3. How much do you smoke? ☐Less than 1 pack/day ☐1 pack/day ☐More than 1 pack/day
4. How much do you chew? ☐Less than 1 can/week ☐1 can/week ☐More than 1 can/week
5. What is your level of interest in quitting? 0 1 2 3 4 5 6 7 8 9 10

Work

1. Does your work schedule vary from week to week? ☐No ☐Yes
2. Does your job require sitting for much of the day? ☐No ☐Yes
3. Is there opportunity to get up and move around? ☐No ☐Yes

Family History

Arthritis	☐ Parent	☐ Sibling	Gall bladder problems	☐ Parent	☐ Sibling	Liver problems	☐ Parent	☐ Sibling
Cholesterol	☐ Parent	☐ Sibling	Heart problems	☐ Parent	☐Sibling	Obesity	☐ Parent	☐ Sibling
Cancer	☐Parent	☐ Sibling	High blood pressure	☐Parent	☐ Sibling	Osteoporosis	☐ Parent	☐ Sibling
Diabetes	☐ Parent	☐ Sibling	High cholesterol	☐ Parent	☐ Sibling	Stroke	☐Parent	☐ Sibling
Eating disorder	☐ Parent	☐ Sibling	Kidney problems	☐ Parent	☐ Sibling	Thyroid	☐ Parent	☐ Sibling

Current Medications/Vitamins

Medication/Vitamin	Dosage	Medication/Vitamin	Dosage
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Conditions/Symptoms					
Acne	☐Yes ☐No ☐Unsure	Diabetes	☐Yes ☐No ☐Unsure	Liver problems	☐Yes ☐No ☐Unsure
Adrenal fatigue	☐Yes ☐No ☐Unsure	Digestive problems	☐Yes ☐No ☐Unsure	Low back pain	☐Yes ☐No ☐Unsure
Allergies	☐Yes ☐No ☐Unsure	Eating disorder	☐Yes ☐No ☐Unsure	Low blood pressure	☐Yes ☐No ☐Unsure
Anxiety	☐Yes ☐No ☐Unsure	Edema (swelling)	☐Yes ☐No ☐Unsure	Low blood sugar	☐Yes ☐No ☐Unsure
Arthritis	☐Yes ☐No ☐Unsure	Fibromyalgia	☐Yes ☐No ☐Unsure	Low energy	☐Yes ☐No ☐Unsure
Asthma	☐Yes ☐No ☐Unsure	Food sensitivities	☐Yes ☐No ☐Unsure	Metabolic syndrome	☐Yes ☐No ☐Unsure
Brain fog/poor concentration	☐Yes ☐No ☐Unsure	Frequent colds or flu	☐Yes ☐No ☐Unsure	Menopause	☐Yes ☐No ☐Unsure
Breastfeeding	☐Yes ☐No ☐Unsure	Gallbladder problems	☐Yes ☐No ☐Unsure	Migraine headaches	☐Yes ☐No ☐Unsure
Burning skin	☐Yes ☐No ☐Unsure	Gout	☐Yes ☐No ☐Unsure	Mood swings	☐Yes ☐No ☐Unsure
Cancer	☐Yes ☐No ☐Unsure	Heart attack	☐Yes ☐No ☐Unsure	Night sweats	☐Yes ☐No ☐Unsure
Candida	☐Yes ☐No ☐Unsure	Heart condition	☐Yes ☐No ☐Unsure	Polycystic Ovarian Syndrome	☐Yes ☐No ☐Unsure
Cardiovascular disease	☐Yes ☐No ☐Unsure	Heart disease	☐Yes ☐No ☐Unsure	Poor dexterity	☐Yes ☐No ☐Unsure
Cellulite	☐Yes ☐No ☐Unsure	Heartburn	☐Yes ☐No ☐Unsure	Pregnancy	☐Yes ☐No ☐Unsure
Chemical sensitivities	☐Yes ☐No ☐Unsure	Heavy metal toxicity	☐Yes ☐No ☐Unsure	Rashes	☐Yes ☐No ☐Unsure
Cholesterol	☐Yes ☐No ☐Unsure	Hernia	☐Yes ☐No ☐Unsure	Shortness of breath	☐Yes ☐No ☐Unsure
Chronic fatigue	☐Yes ☐No ☐Unsure	High blood pressure	☐Yes ☐No ☐Unsure	Sinus problems	☐Yes ☐No ☐Unsure
Chronic headaches	☐Yes ☐No ☐Unsure	High cholesterol	☐Yes ☐No ☐Unsure	Skin eruptions	☐Yes ☐No ☐Unsure
Cold hands and feet	☐Yes ☐No ☐Unsure	High triglycerides	☐Yes ☐No ☐Unsure	Sleep apnea	☐Yes ☐No ☐Unsure
Constipation	☐Yes ☐No ☐Unsure	Hormone issues	☐Yes ☐No ☐Unsure	Stomach problems	☐Yes ☐No ☐Unsure
Craves junk food	☐Yes ☐No ☐Unsure	Inflammation	☐Yes ☐No ☐Unsure	Thyroid problems	☐Yes ☐No ☐Unsure
Craves sweets	☐Yes ☐No ☐Unsure	Irregular menstrual cycle	☐Yes ☐No ☐Unsure	Tremors	☐Yes ☐No ☐Unsure
Dark circles under the eyes	☐Yes ☐No ☐Unsure	Joint pain	☐Yes ☐No ☐Unsure	Trouble sleeping	☐Yes ☐No ☐Unsure
Depression	☐Yes ☐No ☐Unsure	Kidney problems	☐Yes ☐No ☐Unsure		

Exercise/Activity			
Exercise/Activity	**Frequency**	**Exercise/Activity**	**Frequency**
1.		5.	
2.		6.	
3.		7.	
4.		8.	
Previous Diets/Systems			
Diet/System	**Result (pounds lost/gained)**	**Diet/System**	**Result (pounds lost/gained)**
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Eating Habits

1. How many meals per day do you eat? _____

2. How do you rate the overall nutritional content of your current diet? ☐Excellent ☐Very good ☐Satisfactory ☐Poor ☐Unsure

3. How do you rate your own ability to plan menus day after day to meet your health and fitness goals?
☐Excellent ☐Very good ☐Satisfactory ☐Poor ☐Unsure

4. What time of the day are you usually the hungriest?
☐Early morning ☐Mid-morning ☐Noon ☐Mid-afternoon ☐Evening ☐Late night

5. What is your largest meal of the day? ☐Breakfast ☐Lunch ☐Dinner

6. Which, if any, foods do you crave often? ☐Sweets ☐Salty ☐Carbs ☐Other_____

7. Do you believe any of the following have contributed to your weight issues? (Check all that apply)
☐Anger/Frustration ☐Being with others (co-workers, celebrations) ☐Boredom ☐Depression ☐Desserts ☐Drinking alcohol ☐Eating out ☐Eating the wrong type of food ☐Eating too big of portions ☐Eating while watching TV or movies ☐Fast foods ☐Fatty foods ☐Food as reward ☐Frequent snacking ☐Genetics ☐Happiness ☐Holidays ☐Inconsistent meal times ☐Nervousness/anxiety ☐No support ☐Not enough exercise ☐Poor planning ☐Quitting smoking ☐Second helpings ☐Sedentary lifestyle ☐Skipping meals ☐Sight and smell of food ☐Soft drinks ☐Stress ☐Sugar/sweets ☐Work ☐Other_____

During the last 2 weeks, I (check all that apply):	
☐Felt food was controlling me	☐Had plenty of choice in the food I ate
☐Was hungry between meals	☐Ate enough food to be satisfied
☐Snuck food	☐Tasted and enjoyed foods without guilt
☐Was nagged by my friends/family about the food I ate	☐Took time to eat the food that was best for me
☐Beat myself up when I ate the food I felt I shouldn't have	☐Took time to shop for and prepare the food that was best for me
☐Created stress with my family/friends over my food needs	☐Took time for myself
☐Found it difficult to stick to the food I thought I should eat while with family/friends	☐Had someone I could talk to who understood the struggles I have had with food
☐Was confused about the food I should eat	☐Was pleased with the way I managed what I ate
☐Rewarded myself with food	☐Was happy about the food I ate
☐Felt frustrated about limiting the food I ate	☐Knew the amount of food I could eat
☐Was angry I had to change what and how I ate	☐Made healthy food choices
☐Liked the way I look	☐Ate the recommended amount
☐Liked the way my clothes fit	☐Ate when I should have
☐Knew what type of food I should have been eating for a healthy lifestyle	☐Felt confident I could trust myself when faced with difficult food choices
☐Felt changing the food I ate would make life more enjoyable for me	☐Felt confident I would be able to live the rest of my life with healthy changes to my diet

Beverage Intake	
Please mark how many 8-ounce servings per day you usually consume of these beverages.	
Beer ☐None ☐Occasional ☐1-2 ☐3-5 ☐6+	**"Other" Milk (coconut/almond, etc.)** ☐None ☐Occasional ☐1-2 ☐3-5 ☐6+
Coffee (no caffeine) ☐None ☐Occasional ☐1-2 ☐3-5 ☐6+	**"Other" Milk-based drinks (lattes, Frappucino, etc.)** ☐None ☐Occasional ☐1-2 ☐3-5 ☐6+
Coffee (with caffeine) ☐None ☐Occasional ☐1-2 ☐3-5 ☐6+	**Soda (Diet)** ☐None ☐Occasional ☐1-2 ☐3-5 ☐6+
Fruit smoothies ☐None ☐Occasional ☐1-2 ☐3-5 ☐6+	**Soda (Regular)** ☐None ☐Occasional ☐1-2 ☐3-5 ☐6+
Juice ☐None ☐Occasional ☐1-2 ☐3-5 ☐6+	**Tea (no caffeine)** ☐None ☐Occasional ☐1-2 ☐3-5 ☐6+
Liquor ☐None ☐Occasional ☐1-2 ☐3-5 ☐6+	**Tea (with caffeine)** ☐None ☐Occasional ☐1-2 ☐3-5 ☐6+
Cow's Milk ☐None ☐Occasional ☐1-2 ☐3-5 ☐6+	**Water** ☐None ☐Occasional ☐1-2 ☐3-5 ☐6+
Cow's Milk-based drinks (lattes, Frappucino, etc.) ☐None ☐Occasional ☐1-2 ☐3-5 ☐6+	**Wine** ☐None ☐Occasional ☐1-2 ☐3-5 ☐6+
Food Intake	
Please mark how many servings per day you usually consume of these foods.	
Baked goods ☐None ☐Occasional ☐1-2 ☐3-5 ☐6-8 ☐9-11	**Meat(red meat or poultry)** ☐None ☐Occasional ☐1-2 ☐3-5 ☐6-8 ☐9-11
Dairy (milk, yogurt, cheese, etc.) ☐None ☐Occasional ☐1-2 ☐3-5 ☐6-8 ☐9-11	**Salty snacks (chips, crackers, etc.)** ☐None ☐Occasional ☐1-2 ☐3-5 ☐6-8 ☐9-11
Eggs ☐None ☐Occasional ☐1-2 ☐3-5 ☐6-8 ☐9-11	**Starches (bread, pasta, potato, cereal)** ☐None ☐Occasional ☐1-2 ☐3-5 ☐6-8 ☐9-11
Fats (butters, margarine, mayo, oils) ☐None ☐Occasional ☐1-2 ☐3-5 ☐6-8 ☐9-11	**Sweets (candy, etc.)** ☐None ☐Occasional ☐1-2 ☐3-5 ☐6-8 ☐9-11
Fish ☐None ☐Occasional ☐1-2 ☐3-5 ☐6-8 ☐9-11	**Vegetables** ☐None ☐Occasional ☐1-2 ☐3-5 ☐6-8 ☐9-11
Fruits ☐None ☐Occasional ☐1-2 ☐3-5 ☐6-8 ☐9-11	
Dining Out	
Average number of home-prepared meals eaten per week: _____	**Average number of restaurant meals (sit-down, fast food, take-out) eaten per week: _____**
Average number of heat-and-serve meals eaten per week: _____	**My restaurant meals tend to be (check all that apply):** ☐Breakfast ☐Lunch ☐Dinner
When eating out, I tend to "clean my plate": ☐Always ☐Most of the time ☐50% of the time ☐Occasionally ☐Never	

Goals

1. What is your current height? _____
2. What is your ideal weight? _____
3. How much weight would you like to lose?_____
4. What was your approximate weight at high school graduation?_____
5. Have you gained or lost weight recently? ☐No ☐Yes
6. If yes, how much? _____
7. In what time frame? _____
8. What is your highest weight as an adult? _____
9. What is your lowest weight as an adult? _____
10. How long have you been overweight? _____
11. What is you level of interest in losing weight? 0 1 2 3 4 5 6 7 8 9 10
12. What most influenced your decision to seek our assistance with your weight loss efforts?_____
_____
13. Would you be willing to make some lifestyle changes to achieve this weight loss goal? ☐No ☐Yes
14. If not, please explain _____
15. What do you dislike the most about being overweight? _____
16. What health difficulties are you experiencing that you feel are due to being overweight?_____
_____
17. What is your biggest challenge regarding weight loss? _____
18. In general, during the past 6 months, how important has your weight or body shape been in how you feel about yourself as a person?
☐Weight and body shape were not very important.
☐Weight and body shape played a part in how I felt about myself.
☐Weight and body shape were among the main things that affected how I felt about myself.
☐Weight and body shape were the most important factors in how I felt about myself.
19. Are any of your family or closest friends overweight?
☐Spouse/significant other ☐Children ☐Parents ☐Siblings ☐Closest friends
20. Is your family supportive of your weight loss efforts? ☐No ☐Yes
21. Who is your biggest supporter? _____
22. Who else will be positive influences in your weight loss efforts? _____
23. Is anyone likely to sabotage your efforts? ☐No ☐Yes
24. If yes, who? _____
25. Who else may be a negative influence in your weight loss efforts? _____

Goal Analysis

Reasons I want to reach my ideal weight goal (check all that apply):

☐I want to get healthy	☐I want to be able to get pregnant
☐I want to prevent pre-diabetes or diabetes	☐I want to better control my diabetes
☐I want to be able to walk/exercise without pain in my joints	☐I want to heal my sleep apnea
☐I want to prevent heart disease and stroke	☐I want to avoid further heart problems
☐I want to feel comfortable in airline/theater seats	☐I want to look good in new clothes and improve my self-esteem and self-image
☐I want to have more energy, focus, and mental clarity	☐I want to have more choices in life
☐I want to breathe right	☐I want to improve my blood pressure
☐I want to stay healthy	☐I want to balance my hormones
☐I want to improve my mobility, exercise, & activity tolerance	☐I want to live longer

Specific Goals

Please list the three most important reasons you would like to lose weight. These shouldn't be generalizations but rather specific personal reasons that actually mean something to you. It is important to list these out both as a guide for us to help you and as motivation for you to help you reach your ideal weight. Please be assured your answers are confidential.
1._____
2. _____
3. _____

Ultimate Truth Statement
I weigh _____ pounds and I wear a size _____ dress/jeans.
Ideal Statement
I am meeting my health goals. I am healthy, and I weigh _____ pounds and wear a size _____ dress/jeans.

For office use only:

Height:	Weight:	Blood pressure:
Pulse:	O_2:	BMI:
Body fat %:	Lean muscle mass %:	Basal metabolic rate:
Desired weight:	Desired BMI:	
Neck:	Chest:	Stomach:
Hips:	Arms: L_____/R_____	Thighs: L_____/R___