



1951 Bench Rd., Suite B – Pocatello, ID – 83201 – 208.238.1000 – FAX – 208.238.0009

Cardiometabolic Risk Reduction Clinic (CRRC) Initial Visit Questionnaire

Patient Name: _____ Date: _____

Age: _____ D.O.B.: _____ Phone: _____ E-mail: _____

WEIGHT HISTORY AND QUESTIONS

What was your most recent weight? _____ What do you feel is a healthy weight for you? _____

Have you had any recent weight changes? _____ If yes, why? _____

What weight loss programs or efforts have you tried in the past? _____

Are you interested in losing weight now? _____ Do you have support in your efforts? _____

PHYSICAL ACTIVITY HISTORY AND QUESTIONS

Describe the type of physical activities that you do regularly and how often you do them.

Type of activity	How many times each week?	How many minutes each time?

Please read the questions below carefully, and answer each one honestly. Please mark YES or NO.

Has your health care provider ever said that you have a heart condition and that you should only do physical activity recommended by a health care provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel pain in your chest when you do physical activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the past month, have you had chest pain when you were not doing physical activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel any other types of pain when walking or doing any other activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you lose your balance because of dizziness or do you ever lose consciousness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your health care provider currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your doctor instructed you to restrict any activities? If yes, please explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you know of any other reason why you should not do physical activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have other barriers or challenges that limit your ability to be physically active? If yes, please explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No

FOOD FREQUENCY QUESTIONNAIRE

Please mark how often you eat the foods listed below by putting a mark in the daily, 5-6 days/week, 3-4 days/week, 1-2 days/week, or never box.

Food Eaten	Daily	5-6 days a week	3-4 days a week	1-2 days a week	Less than weekly	Never
Beef (please list types)						
Pork (please list types)						
Chicken, no skin						
Chicken, with skin						
Deli meats (please list types)						
Fish (please list types)						
Milk (circle type) skim 1% 2% whole						
Cheese (circle type) low-fat regular						
Yogurt (circle type) low-fat regular						
Ice cream(circle type) low-fat regular						
Eggs						
Butter						
Margarine						
Sour cream (circle type) low-fat regular						
Salad dressings (circle type) low-fat regular						
Commercial cookies						
Commercial crackers						
Snack chips						
Fried foods (please list types)						
Fast foods						
Soda pop (regular or diet)						
Sweets (please list types)						
Fruit						
Juice (list types)						
Vegetables						
Whole grain bread						
Whole grain cereal						
Oats/oatmeal						
Barley						
Avocado						
Flaxseed (circle type) ground seed oil						
Nuts (list types)						
Soy products						
Vegetable oils (list types)						
Other fats used in cooking:						
Water						
Alcohol of any kind						
Other beverages (please list)						
Salt shaker						
Processed foods (canned soup, boxed foods)						
Regular sugar						
Artificial sweeteners						
Other foods you frequently eat:						

NUTRITION HISTORY AND QUESTIONS

How many meals do you eat each day? _____ How many meals do you skip each day? _____

How many snacks do you eat each day? _____ What are your snack choices? _____

Where do you typically eat your meals/snacks? _____

How often are you eating meals away from home? (Please circle a choice below.)

Daily 5-6 days a week 3-4 days a week 1-2 days a week Less than weekly Never

Where do you typically eat out? _____

Are you aware of when you feel hunger? Yes No Are you aware of when you feel full? Yes No

What are your reasons for eating? _____

What are some of the foods that you feel are “problem” foods or foods that you eat too often?

Who usually prepares the food/meals? _____ Who usually does the food shopping? _____

Do you or the person who shops read food labels? Yes No

Have you ever followed any other special type of eating plan? Yes No

If yes, please describe: _____

What do you feel are your challenges for having a healthier lifestyle? _____

What do you want to achieve during your first CRRC visit? _____

SLEEP AND MOOD ASSESSMENT QUESTIONS

Have you ever been told that you snore? Yes No

Do you experience sleepiness during the day? Yes No

How many hours do you usually sleep on average each night? _____

During the past month, have you often been bothered by feeling down, depressed or hopeless? Yes No

During the past month, have you often been bothered by little interest or pleasure in doing things? Yes No

RELEASE OF INFORMATION

I understand that my lab results will sometimes be discussed with me by telephone. I can be reached best at the following telephone number(s):

Home: _____ Hours: _____

Work: _____ Hours: _____

If I am unavailable, I authorize the InterMountain Medical Clinic CRRC staff to discuss these results with the following person.

Name: _____ Relationship: _____

I understand that my enrollment in the InterMountain Medical Clinic CRRC includes my authorization for the release of information regarding my progress to my primary care physician.

Signature: _____ Date: _____