Admisson information

Please fill in the form as concise as possible.

General information:	
Name	
Phone/email adress/adresse	
Date of birth	
Job	
Family, children	
Height	
Weight	
Abdominal girth	
Smoker or non-smoker?	O non-smoker since_____ O occasionally O up to 20 cigarettes per day O more than 20 cigarettes per day
Information about health issues, operations, medication:	
Are you suffering from any health issues? If yes, which? (e.g. high blood pressure, thyroid, cardiac diseases, back pain,…)	
Have you had any serious medical interventions in the past? If so, which and when?	
Are you taking any medication? If yes, which?	
Diets, fasting cures, in-patient stays or pills to lose weight? (Which, when and with what result?)	
Are you suffering from digestion problems?	O no O diarrhea O constipation O flatuence

Level of stress (work)	O low O intermediate O high
Level of stress (private)	O low O intermediate O high
Sleep disturbances	O I wake up at night O I can't fall asleep O My sleep is uneasy O I have stressing dreams
Information about physical exercise:	
Are you praciticing sports? If yes, which and how often?	
Information about weight:	
How do you feel?	O overweight O normal weight O underweight
What could be the reason for this?	O too many calories O too little calories O too much fat O too many sweets O eating disorder O alcohol O business lunches O cantine food O predisposition O irregular meals O not enough meals
How old were you when you became overweight?	
How old were you when you wanted to lose some weight fort he first time?	
What is your target weight?	
How did you use to maintain your weight?	
Information about nutrition:	
How many meals do you eat per day?	
Do you leave out meals? If "yes", which? (e.g. breakfast, lunch, dinner)Abendessen)	

Do you like to eat “sweet“ food? If so, which sweets do you like the most?	
Which drinks (e. g. water, coke, fanta, tea, lemonade, fruit juice,…) do you regularly consume? How many litres per day?	
Are you using any food supplements? If „yes“, which? (e.g. vitamins, minerals, proteins,…)	

Information about food intolerances, allergies:

Which oft he following food ingredients/food do you not tolerate?	O lakctose O fruktose O gluten O nuts O citrus fruit Other:

Information about eating habits:

Which food do you mostly eat?	

How often do you consume the following foods?
Please tick the boxes:

	never	rarely	1x per week	several times a week	daily
Fruit					
Vegetables					
Salad					
Cereal produkts/bread					
Dairy					
Eggs					
Meat					
Sausage					
Fish					
Cheese					
Sea food					

What do you eat for these meals?	
Breakfast	
Snack	
Lunch	
Snack	
Dinner	
Other	

Calculation of activity supplement:

How much time do you spend per day (in total: 24 h)	
Sitting/lying (e.g. sleeping, watching tv,…)	
Sitting, very little activity (e.g. z. B. computer work, reading,…)	
Sitting, walking and standing (e.g. at work, at home,…)	
Mainly standing and walking (e.g. taking walks, maybe at work,…)	
Physically demanding work (e.g. sports, exhausting housework,…)	

Other information that might be important for us

_____

Date, signature