Welcome to our office. We look forward to helping you meet your goals!

PERSONAL INFORMATION Date: ____________________

Name: ____

Address: ____

City, State, Zip: ____

Telephone (*Home*): ______________________________ (*Mobile*): ______________________________

Date of Birth: ______________ Age: _________ Height: ____________ Email: ______________________

Occupation: _________________________________ Spouse Occupation: _________________________

Employed By: ____

Clinic Notes:

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HOW WERE YOU REFERRED TO OUR OFFICE?

Friend of family: ________________________ Online: ________________ Other: ____________

Radio: ________ Which Station?___________ Newspaper Ad: __________ Street Sign: ________

MEDICAL HISTORY

Do you or any family member have/had any of the following? Please put an "✓" for you, or an "**F**" for family

_____ Depression
_____ Heart Attack
_____ Diabetes
_____ Thyroid Disease
_____ Kidney Disease
_____ Epilepsy
_____ Organ Transplant
_____ Stroke
_____ Hypoglycemia
_____ Anemia
_____ Cancer
_____ High Blood Pressure
_____ Intestine Problems
_____ Gallbladder Disease
_____ Headache
_____ Neck Pain
_____ Poor Sleep
_____ Dizziness
_____ Arthritis
_____ High Cholesterol
_____ Shortness of Breath
_____ Gout
_____ Mid Back Pain
_____ Low Back Pain
_____ Carpal Tunnel

List any surgeries you have had____

Are you taking any medications? ________ If Yes, please list ____

____

Are you pregnant? __________ How many children? __________ Are you breast feeding? ___________

Do you Smoke?_____________ Drink?__________

How much water do you typically drink in a day? ____

Any Known Allergies? ___________ If yes, please list____

Your Primary Care Physician and full address: ____

____

HISTORY

How long have you been overweight? ____

Have you tried to lose the weight in the past? How?____

Has your doctor recommended you to lose weight? ____

Can you attribute the gain to anything? ____

What are your TOP 2 reasons why you want to lose weight?

Name ________________________________

What is your energy level on a scale of **1-10**, with 1 being the lowest and 10 the highest? ___________

On average, how many hours of sleep do you get each night? __________________________

How many times do you eat out at a restaurant during an average week? ________________

GOALS

What is your Goal Weight? ____

When was the last time you were at that weight?____

How much weight have you lost and gained then lost and gained in the past? _________________________

On a scale of **1-10**, with 10 meaning "*I'm fully committed, I want to start right now*", & 1 meaning "*I'm not interested*" - What is your current level of commitment? ___________________________________

Weight Loss Program Information

FOR THIS NEXT SECTION PLEASE ANSWER THE FOLLOWING QUESTIONS HONESTLY SO WE CAN DO OUR BEST TO HELP YOU REACH YOUR GOALS.

Check ALL areas of treatment that interest you:

☐ Weight Loss ☐ Cleansing and Detoxification ☐ General Wellness ☐ More Energy ☐ Stress Reduction ☐ Other
Did you know that all treatments above are 100% safe? ☐ YES ☐ NO
Have you ever used any of the treatments above? ☐ YES ☐ NO
Does your weight problem make you physically uncomfortable? ☐ YES ☐ NO **If yes, please explain:**
Does your weight problem cause physical pain? ☐ YES ☐ NO **If yes, please explain:**
Are you embarrassed by your excessive weight? ☐ YES ☐ NO **If yes, please explain:**
Does being overweight and unhealthy limit your activities? ☐ YES ☐ NO
Do you binge eat? ☐ YES ☐ NO
Do you suffer from uncontrollable cravings? ☐ YES ☐ NO

Name ________________________________

Do you feel that food controls you? ☐ YES ☐ NO
Do you eat because of your emotions? ☐ YES ☐ NO
Do you eat between meals? ☐ YES ☐ NO
What do you choose to eat between meals?

Briefly describe your daily eating behaviors:
Do you feel that your eating behaviors are normal? ☐ YES ☐ NO
Do you feel tired, run down, or out of energy? ☐ YES ☐ NO
How fast do you want to be slim, trim, and fit?
What's more important to you: fast or permanent?
Does your family support your weight loss efforts? ☐ YES ☐ NO
Can you remember being at your ideal weight? ☐ YES ☐ NO

Please return intake to the Front Desk when completed