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: _____

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 weight in the past? How?_____

Has your doctor recommended you to lose weight? _____

Can you attribute the gain to anything? _____

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
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