

New Patient Weight Loss Intake Form

Basic Patient Information

Name:		Date:	
Street Address:			
City:		State:	Zip:
Home Phone:		Cell Phone:	
Email Address:			
Sex: M F	Age:	Birth date:	Height: Weight:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced			
Occupation:		Hobby:	
How did you hear about us?			

Health and Wellness History

Are you currently under the care of a physician?	
Are you taking any medications?	
Has your doctor advised you to lose weight?	
Do you have any dietary restrictions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please explain:	
How often do you exercise?	What type of exercise?
Do you feel stressed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please explain:	
Check ALL that apply to you: <input type="checkbox"/> Heart Condition <input type="checkbox"/> Epilepsy/Seizures <input type="checkbox"/> Pregnant <input type="checkbox"/> Might Be Pregnant <input type="checkbox"/> Taking Heart Medication/Blood Thinners <input type="checkbox"/> Currently Undergoing Chemotherapy <input type="checkbox"/> Breast Feeding <input type="checkbox"/> Known Adverse Reactions to Niacin or B Vitamins	

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:

<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Cleansing and Detoxification	<input type="checkbox"/> General Wellness	<input type="checkbox"/> Body Wraps
<input type="checkbox"/> More Energy	<input type="checkbox"/> Stress Reduction	<input type="checkbox"/> Other	

Did you know that all treatments above are 100% safe?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever used any of the above treatments before?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What do you consider to be your ideal weight?	
How much weight do you want to lose?	
When was the last time you were at your goal weight?	
How many times a year do you diet?	
What is stopping you from losing weight on your own?	
What have you tried in the past that has failed?	
Does your weight problem make you physically uncomfortable?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please describe:	
Does your weight problem cause physical pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please describe:	
Are you embarrassed by your excessive weight?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please describe:	

Does being overweight and unhealthy limit your activities?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you binge eat?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you suffer from uncontrollable cravings?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel that food controls you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you eat because of your emotions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you eat between meals?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What do you choose to eat between meals?		
Do you feel that your eating behaviors are normal?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Briefly describe your daily eating behaviors:		
Do you feel tired, run down, or out of energy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is successful weight loss a top priority?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Please explain:		
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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your family excited that you're working with us?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Can you remember being at your ideal weight?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What do you remember most about it?		
Can you remember being at your ideal weight?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What do you remember most about it?		

Check the following conditions you would like help with or more information on:

<input type="checkbox"/> Cleansing	<input type="checkbox"/> Cellulite	<input type="checkbox"/> Fitness	<input type="checkbox"/> Hormone Balance for Men
<input type="checkbox"/> Hormone Balance for Women	<input type="checkbox"/> Immune Boosting	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Memory & Mood
<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Pain Relief	<input type="checkbox"/> Quitting Smoking	<input type="checkbox"/> Skincare
<input type="checkbox"/> Stress Relief	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Wellness

What is the most important element in deciding to use our services?

Circle only ONE of the four answers:

- EFFECTIVENESS: "My results are my top priority."
 TIME: "I want results quickly."
 SERVICE: "I need extra support along the way."
 AFFORDABILITY: "I need this to be affordable."

I understand that my entire patient history will remain completely confidential and will not be released without express written consent from me.

Signature: _____ Date: _____