New Patient Intake Form

Basic Patient Information

Name: _____ Date: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____ Occupation: _____
Sex: M F Age: _____ Birth Date: _____ Height: _____ Weight: _____
Marital Status: □ Single □ Married □ Separated □ Divorced
Who may we thank for referring you? (Circle One)
Acorn Go City Shopper VC Star VC Star Insert Google Internet

Facebook KBBY 95.1 Postcard Friend: _____

Health and Wellness History

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 □ Overall Heath □ Other
□ Improving Energy □ Stress Reduction □ Better Sleep

Have you received treatment for any of the above? □ Yes □ No
Do you have any dietary restrictions? _____
Name of M.D. if currently under care? _____
Has your doctor advised you to lose weight? _____
When was the last time you were at your goal weight? _____
How much weight do you want to lose? _____
What is stopping you from losing weight all on your own? _____
Does your weight problem make you physically uncomfortable? □ Yes □ No
Please explain: _____
Does your weight problem cause physical pain? □ Yes □ No
Please explain: _____
Are you embarrassed by your excessive weight? □ Yes □ No
Please explain: _____
Does being overweight and unhealthy limit your activities? □ Yes □ No
Please explain: _____
Do you binge eat? □ Yes □ No
Do you suffer from uncontrollable cravings? □ Yes □ No
Do you feel food controls you? □ Yes □ No
Do you eat for emotional reasons (stress, anger, sadness, etc.) □ Yes □ No
Do you eat between meals? □ Yes □ No
What do you choose to eat between meals? _____
Briefly describe your daily eating behavior: _____
Do you feel you're eating behavior is normal? _____

Health and Wellness History (Continued)

Do you feel tired, run down and out of energy? _____
Is successful weight loss a top priority? □ 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
Is your family excited about you coming here for weight loss? □ Yes □ No
Can you remember being your ideal weight? □ Yes □ No
What do you remember most about it? _____
_____

What is the most important element for you 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."**
AFORDABILITY:	**"What you charge is my concern."**

Medical History

Have you had surgery in the past? _____
Are you pregnant? _____ How many Children? _____ Are you breast feeding? _____
Do you or any family member have/had any of the following? If family member put "F"
___ Depression ___ Epilepsy ___ Heart Attack ___ Cancer ___ Hypoglycemia
___ Neck Pain ___ Diabetes ___ Anemia ___ Poor Sleep ___ Thyroid Disease
___ Arthritis ___ Gout ___ Stroke ___ Intestine Problems ___ Carpal Tunnel
___ Kidney Disease ___ Mid Back Pain ___ Low Back Pain ___ Shortness of Breath
___ High Cholesterol

Please list any medications:

Medications:	**Used for:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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

Patient Name: _____ Date: _____

Signature: _____