

		Today's Date:	/ /			
General Information						
Last Name:	First Name:					
Date of Birth: / / Current Age	Occupat	ion				
Marital Status: S M D W	Gender:	Male Fe	emale			
Address:	Home Phone:					
City:	Work Phone:					
State:	Cell Phone:					
Zip Code:	Email Address					
Are you a former client? Y N If yes, which location? Date of last visit? / / Emergency Contact Information						
Name:	Phone:					
Relationship:						
Referral Source						
How did you hear about us?						
Friend (Name)	Internet Sea	arch Sales F	Rep			
Co-worker (Name)	Mail Invitati	on Physic	ian			
Radio	Phone	Email				
Groupon Ad / Internet Ad						

Reviewed by:_____



Medical History

Please indicate if you (self) or any blood relative has or has had any of the following conditions:

Relative	Self		Relative	Self	
		Abdominal Pain			Hemorrhoids
		Accident (major)			Hepatitis
		Alcoholism / Drug Addiction			High Blood Pressure
		Allergy (any)			High Cholesterol
		Anemia			HIV / Aids
		Anorexia			Hot or Cold Flashes
		Anxiety			Increased Urination
		Arthritis			Irritable Bowel Syndrome
		Asthma			Joint or Muscle Aches
		Bad Taste in Mouth			Jaundice
		Back Pain			Kidney Disease
		Excessive Belching or Bur			Liver Disease
		Bladder Problems			Lung Disease
		Bleeding			Memory Lapses
		Blood / Stones / Pus in U			Mental Illness
		Blood Transfusion			Nail or Cuticle Problems
		Bulimia			Nausea or Vomiting
		Chest Pain			Neurological Disorder
		Cancer / Tumor			Osteopenia / Osteoporosis
		Constipation			Pain or Burning with Urination
		Coughing			Palpitations
		Depression			Paralysis
		Diabetes			Pneumonia
		Dry Skin			Poisoning / Medication Overdose
		Eczema			Recent Change in Bowel Habits
		Epilepsy / Seizures			Recurrent Colds
		Fainting / Dizziness			Ringing or Buzzing in Ears
		Gall Stones			Rheumatic Fever
		Gland Problems			Sexually Transmitted Disease
		Gastritis			Sleep Problems
		Goiter			Shortness of Breath
		Gout			Sinus Trouble
		Hair Loss			Stomach / Intestine / Colon Disorder
		Headache / Migraine			Swollen Legs / Ankles / Feet
		Heartburn			Stroke
		Heart Disease			Thyroid Disease
		Tuberculosis			Unusual Thirst
		Vision Problems			Varicose Veins

Other Medical Problems:

Reviewed by:_____



Surgical History & Hospitalizations

Surgical History:			Hospitaliz	ation	IS:			
Date	Operation			Date		Illness / Injury		
Family / Socia	al Histor	гy						
Father Decea	sed	Yes	No	Age:	Cause	of De	eath:	
Mother Decea	ased	Yes	No	Age:	Cause	of De	eath:	
Do you smoke or use any tobacco products?			products?		Yes	No		
Do you use any illegal or street drugs?					Yes	No		
How many hours of sleep do you get on an average night?								
Do you work a night shift?				Yes	No			
If so, how many nights per week?				per week?	[]

Medications & Allergies

Medications (list current medications)

Name	Dose				

Allergy History (list any allergy you have had)

Name



Yes

No

Medications & Allergies (continued)

Vitamins, Minerals & Supplements (list current supplements)

Name

Diet & Activities

What is the lowest weight as an adult that you maintained?

Have you ever had an eating disorder?

What medications or supplements have you taken in the past in an attempt to lose weight? (list all)

What other diets have you tried in the	
past?	

Select your activity level? Inactive Light Moderate Heavy Vigorous

What types of exercise do you do and how often?

 Why are you having difficulty managing your weight?

 Overeating
 Slow Metabolism

 Stress Eating
 Not exercising enough

 Other:
 Eating

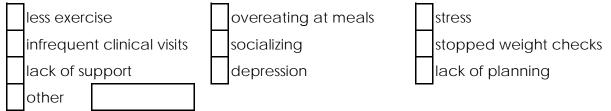
Reviewed by:__



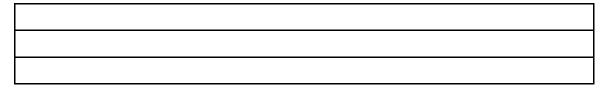
Diet & Activities (continued)

What are your problem meals?	
Breakfast Morning snack Brunch Afte	ernoon snack
Lunch Evening snack	
What foods do you eat too much of?	
Carbohydrates Protein Sweets Fats	Alcohol
How much did you weight at age 18?	
Were you overweight as a child?YesNo	
Do you feel out of control while eating? Yes No	
If so, which foods?	
If you have lost weight, and then regained, please indicate the 3	s most important reasons

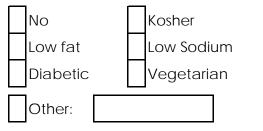
If you have lost weight, and then regained, please indicate the 3 most important reasons for the weight gain:



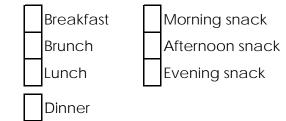
What do you believe will be of the most help to assist you in losing weight?



Do you follow a special diet?



Which meals do you regularly eat?





Diet & Activities (continued)

Do you usually eat out or order food in?				Yes	s No	
How often?	D	aily	Weekly	Monthly	Other	
How is your food u	')			Baked Steamed Boiled		Broiled Poached Fried
What beverages d	o you d	lrink da	ily and ho	ow much?		
Water		8oz gla	asses per	day		
Coffee		cups per day				
Tea		cups per day				
Soda		12oz glasses per day				
Beer		12oz glasses per day				
Wine		6oz glasses per day				
Mixed Drinks		6oz glasses per day				
Other		8 oz glasses per day				
Specify:						