

Full name: _____ Today's date: _____

Preferred name: _____ Marital status: single / married / divorced / widowed / other

Address: _____ City: _____ State: _____ Zip: _____

Contact number: _____ E-mail address: _____

Gender: Male Female Birth date: _____ Social Security #: _____

Occupation: _____ Employer name: _____

Emergency contact name: _____ Phone: _____ Relationship: _____

Primary physician: _____ Office: _____ Date of last visit: _____

How did you hear about us? _____

What is your current weight? _____ Height? _____

What is your current activity level? LOW MODERATE HIGH

What is your "Goal Weight"? _____ When was the last time you weighed that? _____

Has your doctor recommended you to lose weight? YES NO

Have you tried to lose weight in the past? YES NO If "YES", please describe: _____

What are your top 2 reasons why you want to lose weight, improve your health and live well?

1. _____ 2. _____

On a scale of 1-10, with 10 meaning "I'M SERIOUS ABOUT LOSING WEIGHT AND FULLY COMMITTED" what is your current level of commitment? 1 2 3 4 5 6 7 8 9 10

YOUR HEALTH SUMMARY

Please ✓ check all symptoms you have ever had (S=self), even if they do not seem related to your current problem, and mark (F=family) if you have a family history of any of them.

S F

- Stroke
- Heart Attack
- Diabetes
- Thyroid Disease
- Gallbladder Disease
- Kidney Disease
- Liver Disease
- High Blood Pressure
- High Cholesterol
- Shortness of Breath

S F

- Epilepsy
- Hypoglycemia
- Pacemaker
- Organ Transplant
- Intestine problems
- Constipation
- Stomach
- Heartburn
- Gout
- Cancer (Type: _____)

S F

- Headaches
- Neck Pain/Stiffness
- Back Pain/Stiffness
- Loss of Balance
- Dizziness
- Arthritis
- Skin Conditions
- Hair Loss/Thinning
- Bipolar Disorder

S F

- Depression
- Mood Swings
- Stress
- Poor Sleep
- Fatigue
- Hot Flashes
- Cold Feet
- Hysterectomy
- Anxiety

(PLEASE TURN OVER AND COMPLETE OTHER SIDE.)

HEALTH SUMMARY – PAGE 2

List any medications you are taking & what for: _____

List any major hospitalizations, operations or illness: _____

Have you been treated by a physician in the last 12 months? **YES NO**

If "YES", please describe: _____

Are you under regular chiropractic care? **YES NO**

In addition to weight loss, if there was one other health condition or struggle that you would love to see your body heal and/or overcome, what would that be? _____

Please Circle Yes or No to Answer the Questions Below:

YES NO Are you currently taking either, Steroids, Estrogen or undergoing any Hormone Replacement Therapy?

If yes, please explain _____

YES NO Are you currently taking any blood thinners? If yes, please explain _____

YES NO Do you have heart problems? If yes, please explain _____

YES NO Do you take insulin for diabetes? If yes, please explain _____

YES NO Do you suffer from mental illness including anxiety/depression?

If yes, please explain _____

YES NO Are you or have you been suffering from an eating disorder? If yes, please explain _____

YES NO Have you had a serious health complication attempting a detox, weight loss or lifestyle program in the last five years?

If yes, please explain _____

Females only

YES NO Are you pregnant?

YES NO Are you breast feeding?

YES NO Are you on birth control?

PRIMARY CARE MEDICAL WAIVER

*I understand that the information I provided on this document is relative to my capacity of completing any lifestyle program designed and implemented by your establishment and answering **YES** to any of the questions above shall require further discussion with my primary care physician and clearance prior to initiating such program.*

I further acknowledge and agree that, I waive any claims I may have against your establishment, or any of your employees, or agents and agree to hold you harmless and indemnify your establishment, your employees, or agents from and against any and all claims, damages, causes of action or injuries relating to any of the lifestyle programs I enroll in because I understand it is my responsibility to:

- 1. Complete this form with accuracy and to disclose any related information to the questions I completed with integrity.*
- 2. Consult with my primary care physician on any medications, supplements, product interactions, historical and present medical conditions, diagnoses and treatment, prior to, during, and after completing any lifestyle program.*
- 3. I will provide any documentation from my primary care physician to your establishment should it be in relation to the lifestyle program, directly or indirectly.*

CLIENT SIGNATURE _____

DATE _____

PRINT CLIENT NAME _____