



New Patient 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: Single Married Widowed Separated Divorced

Occupation: _____ Hobby: _____

Who may we thank for referring you? _____

Name of M.D. if currently under care? _____

Medical Prescriptions: _____

Has your doctor advised you to lose weight? Yes No

Do you have any dietary restrictions? Yes No

Check ALL that apply to you: Heart Condition Epilepsy/Seizures Pregnant Might Be Pregnant

Taking Heart Medication/Blood Thinners Currently Undergoing Chemotherapy Breast Feeding

Known Adverse Reactions to Niacin or B Vitamins

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 Health Body Wraps
 Improving Energy Stress Reduction Better Sleep Other

Did you know that all of the treatments listed above are 100% safe? Yes No

Have you received treatment for any of the above? Yes No

When was the last time you were at your goal weight? _____

What do you consider your ideal weight? _____

How much weight do you want to lose? _____

How many times a year do you diet? _____

What is stopping you from losing weight all on your own? _____

What have you tried in the past that has failed? _____

Does your weight problem make you physically uncomfortable? Yes No

Please explain: _____

Does your weight problem cause physical pain? Yes No

Please explain: _____



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Health and Wellness History (Continued)

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 your eating behavior is normal? Yes No

Do you feel tired, run down, and out of energy? Yes No

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.”

AFFORDABILITY: “What you charge is my concern.”

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

Signature: _____ Date: _____