

# 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: \_\_\_\_\_

# New Patient Intake Form

## 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: \_\_\_\_\_