New Patient Weight Loss 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:		
How did you hear about us?				

Health and Wellness History

Are you currently under the care of a physician?
Are you taking any medications?
Has your doctor advised you to lose weight?
Do you have any dietary restrictions? ◯ Yes ◯ No
Please explain:
How often do you exercise? What type of exercise?
Do you feel stressed? ◯ Yes ◯ No Explain:
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

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	☐ General Wellness	☐ Body Wraps
☐ More Energy	☐ Stress Reduction	☐ Other	

Did you know that all treatments above are 100% safe? ◯ Yes ◯ No
Have you ever used any of the above treatments before? ◯ Yes ◯ No
When was the last time you were at your goal weight?
What do you consider to be 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 on your own?
What have you tried in the past that has failed?

Does your weight problem make you physically uncomfortable? ○ Yes ○ No
Please describe:
Does your weight problem cause physical pain? ○ Yes ○ No
Please describe:
Are you embarrassed by your excessive weight? ○ Yes ○ No
Please describe:
Does being overweight and unhealthy limit your activities? ○ Yes ○ No
Do you binge eat? ○ Yes ○ No
Do you suffer from uncontrollable cravings? ○ Yes ○ No
Do you feel that food controls you? ○ Yes ○ No
Do you eat because of your emotions? ○ Yes ○ No
Do you eat between meals? ○ Yes ○ No
What do you choose to eat between meals?
Briefly describe your daily eating behaviors:
Do you feel that your eating behaviors are normal? ○ Yes ○ No
Do you feel tired, run down, or 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 that you're working with us? ○ Yes ○ No
Can you remember being at your ideal weight? ○ Yes ○ No
What do you remember most about it?

What is the most important element 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:	"I need this to be affordable."

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

Signature: _____ Date: _____