



Lowest: \_\_\_\_\_ Highest: \_\_\_\_\_

10. Please check all previous programs that you have tried in order to lose weight. Indicate dates, length of program, and any medications with respective dose and frequency.

<b>Program</b>	<b>Date</b>	<b>Medication</b>	<b>Dose/Frequency</b>
Weight Watchers			
Liquid Diets			
Keto Diet			
Diet Pills (Phen-Fen)			
Nutrisystem/Jenny Craig			
Obesity Surgery			

11. Have you maintained any weight loss for up to 1 yr. on any of these programs?  Yes  No

12. What did you learn from these programs regarding your weight?

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13. What did not work about these programs, so we can make changes?

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14. How important is it that you lose weight at this time?

- a. Not
- b. Not Very
- c. Somewhat
- d. Very Important
- e. Imperative

15. What factors led to your success?

- a. Encouragement from others
- b. Determination
- c. Goal- Event with old friends, etc.

16. How does being overweight affect you?

- a. Limits exercise
- b. Can't wear my clothes
- c. Tired all the time
- d. My knees hurt

e. My back hurts

17. What has made weight loss difficult?

- a. Travel
- b. Holidays
- c. Weekends
- d. Parties
- e. Hunger
- f. Cost of care
- g. Peer pressure
- h. Family

18. What is hard about managing your weight?

- a. No will power
- b. I've always been overweight
- c. No exercise
- d. Schedule too busy
- e. Hungry all the time
- f. I don't like vegetables
- g. I'm a meat and potatoes person

19. What beverages do you drink daily and how much?

<b>Drink</b>	<b>Times or 8oz. Glasses Per Day</b>
Water	
Coffee	
Tea	
Soda	
Alcohol	
Other	

21. Would you like to change your eating habits? Yes  No

22. What habits would you like to begin to change?

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23. Is your decision to lose weight your own or for someone else?

- a. Mine
- b. My wife
- c. My husband
- d. My parents

e. My friends

24. Is your family supportive? Yes  No

25. What can't you do now that you would like to do if you weighed less?

- a. Keep up with partner
- b. General activity
- c. Play golf
- d. Go for walks
- e. Play with my children/grandchildren
- f. Get into my old clothes

26. What would you like to get out of this visit regarding your weight?

- a. A diet
- b. Accountability
- c. Understanding about what makes me heavy
- d. Lasting change

What's more important inches lost or pounds?	
Does being overweight and unhealthy limit your activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you binge eat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you suffer from uncontrollable cravings?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel that food controls you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you eat because of your emotions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you eat between meals?	<input type="checkbox"/> Yes <input type="checkbox"/> No
How much weight do you want to lose?	
Do you feel that your eating behaviors are normal?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Briefly describe your daily eating behaviors:	
Do you feel tired, run down, or out of energy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is successful weight loss a top priority?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please explain:	
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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your family excited that you're working with us?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Can you remember being at your ideal weight?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What do you remember most about it?		
What would stop you from a weight loss program?		
Commitment to weight loss: please rate	1 2 3 4 5 6 7 8 9 10	

**Check the following services you would like help with or more information on:**

<input type="checkbox"/> Red Light Fat Loss Therapy	<input type="checkbox"/> Emsculpt Neo	<input type="checkbox"/> Emface	<input type="checkbox"/> Chiropractic Services
<input type="checkbox"/> Acousana Softwave Therapy	<input type="checkbox"/> Massage	<input type="checkbox"/> Recovery Room	<input type="checkbox"/> Infrared Sauna

**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."

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b>Patient Name:</b>			<b>Date:</b>		
<b>Current Medical Providers:</b>					
<b>Medical History</b>					
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Appendicitis	<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Shoulder Pain		
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Pinched nerve	<input type="checkbox"/> Wrist Pain		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Breast lump	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Elbow Pain		
<input type="checkbox"/> Cancer	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Polio	<input type="checkbox"/> Knee Pain		
<input type="checkbox"/> Depression	<input type="checkbox"/> Bulimia	<input type="checkbox"/> Prostate problems	<input type="checkbox"/> Hip Pain		
<input type="checkbox"/> Stroke	<input type="checkbox"/> Chemical	<input type="checkbox"/> Psychiatric care	<input type="checkbox"/> Ankle Pain		

<input type="checkbox"/>	Parkinson's disease	<input type="checkbox"/>	dependency	<input type="checkbox"/>	Suicide attempt	<input type="checkbox"/>	Fibromyalgia
<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Emphysema epilepsy	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	Multiple Sclerosis
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	Balance Issues
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Vaginal infection	<input type="checkbox"/>	Vertigo
<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	Multiple sclerosis	<input type="checkbox"/>	Herniated disc	<input type="checkbox"/>	Whiplash	<input type="checkbox"/>	Sinusitis
<input type="checkbox"/>	Migraine headaches	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	Previous chiropractic care	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	Herniated	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	TMJ
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Miscarriage	<input type="checkbox"/>	Neck Pain		
<input type="checkbox"/>		<input type="checkbox"/>	Pacemaker				

### Family Health History

<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	Chemical dependency	<input type="checkbox"/>	AIDS/HIV
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Multiple sclerosis	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Pinched nerve
<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	Migraine headaches	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	Prostate problems
<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Suicide attempt
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Appendicitis	<input type="checkbox"/>	Herniated disc	<input type="checkbox"/>	Tumors
<input type="checkbox"/>	Parkinson's disease	<input type="checkbox"/>	Bleeding disorders	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Breast lump	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	Vaginal infection
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Bulimia	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	Venereal disease

Medication	Dose	Purpose


**For office use only**

Height	Weight	Waist Circumference	BP
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Provider: \_\_\_\_\_