**Services you are interested in**

**(Please select all that apply):**

* Medical Weight Loss
* Lipo Laser Treatments
* Thyroid/Hormone Treatment
* IV Nutritional Therapy
* Stem Cell Therapy

**New Patient Questionnaire (Health Care Analysis) Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **First Name:** | **Last Name:** | **Email:** |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Address:** | **City:** | **State:** | **Zip Code:** |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Home Phone:** | **Work Phone:** | **Cell Phone:** | **Date of Birth:** |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Age:** | **Height:** | **Weight:** | **Gender:** |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **🞏 Male 🞏 Female** |
| **How did you hear about us?:** | **If referred by someone, who?:** |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Please answer the following questions honestly so we can do our best to help you reach your goals**

Who encouraged you to lose weight?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How important to you is it to lose weight?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What important reason, special occasion, or goal date do you have to lose weight?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many pounds would you like to lose?: \_\_\_\_\_\_\_\_\_\_\_ How fast do you want lose the weight?: \_\_\_\_\_\_\_\_\_\_\_\_\_

Would you commit to one visit a week?: 🞏 Yes 🞏 No

Have you ever attended any other weight reduction centers, if so, which ones?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What kinds of diets have you tried on your own?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the longest you have been able to stick with a diet?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your family support your weight loss efforts?: 🞏 Yes 🞏 No

Have you been advised by your family physician to lose weight?: 🞏 Yes 🞏 No

If you answered Yes, what is your doctor’s name?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you eat because of emotions?: 🞏 Yes 🞏 No

If you answered yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any symptoms you experience that were not previously mentioned: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**What is most important to you in deciding to use our services? (Please check all that apply):**

* Effectiveness “My results are my top priority.”
* Time “I want results quickly.”
* Service “I need extra support along the way.”
* Ease “I have a difficult time losing weight.”

Office use only:

* Genetic Test Serial #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BMI: \_\_\_\_\_\_
* Intermittent Fasting
* Ancestral Fat%: \_\_\_\_\_\_
* Mediterranean
* Keto Metabolic Age: \_\_\_\_\_

**On average, which of the following reflects your daily eating habits? (Please check all that apply):**

* 3 meals with healthy snacks
* 3 meals
* 2 meals or less
* Skip breakfast or other meals
* Generally eat on the run
* No regular eating pattern
* Often crave sweets/carbs
* Graze; small, frequent meals

(How many per day? \_\_\_\_\_\_ )

**Current level of exercise (Please check one that applies):**

* None
* Light exercise (1-3 times per week, easy pace, stretching, walking, etc.)
* Moderate exercise (2-3 times per week, moderate pace, some weights, etc.)
* Heavy exercise: (3-4 times per week, vigorous pace, weights, fast running, etc.)

**Health Information**

**Past or Present Health Conditions (Please check all that apply):**

* Diabetes
* Hypoglycemia
* Strokes
* Heart Disease
* High Blood Pressure
* Hormone Imbalance
* Hormonal Cancer
* Thyroid Imbalance
* Anorexia
* Bulimia
* Drug Addiction
* Currently pregnant or nursing
* Allergic to sulfur, food or medication
* Vegetarian
* Glaucoma
* Diabetes/Hypoglycemia

If you checked any of the above, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized, under medical care, or checked into rehab for alcohol or drug treatment?: 🞏 Yes 🞏 No

If you answered yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please list all medications you are currently taking, including doses and reasons for taking**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication:** | **Dose:** | **How often:** | **Reason:** | **Prescribing M.D.** |
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**Wellness Screen**

**Symptoms (please circle rating)**

1. Decline in general well being

2. Joint pain/muscle ache

3. Excessive sweating/hot flashes

4. Sleep problems

5. Wake up tired

6. Irritability

7. Nervousness

8. Anxiety

9. Depressed mood

10. Exhaustion/lacking vitality

11. Declining mental ability/focus/concentration

12. Decreased muscle strength

13. Weight gain/more belly fat/inability to lose weight

14. Breast tenderness

15. Rapid hair loss

16. Migraine headaches

17. Decreased sexual desire/libido

18. Decreased ability to perform sexually/climax

19. Dry skin

20. Constantly cold

21. Constipation

22. White spots on nails

23. Bruise easily

24. Loud noises bother me

24. Frequent heartburn

**0 – 40** Fairly Healthy

**40 – 60** Some Hormonal Imbalance

**60 and above** Deficiency is Probable

 **NEVER MILD MODERATE SEVERE**

 (some days) (most days) (every day)

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**Total Points =**

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