FULL NAME: _____ TODAY'S DATE: _____

PREFERRED NAME: _____ MARITAL STATUS: SINGLE / MARRIED / DIVORCED / WIDOWED / OTHER

ADDRESS: _____ CITY: _____ STATE:_____ ZIP : _____

HOME ☐_____ WORK ☐_____ CELL ☐_____

EMAIL ADDRESS: _____ GENDER: ☐ MALE ☐ FEMALE

SOCIAL SECURITY #: _____ BIRTH DATE: _____ HEIGHT: _____

OCCUPATION: _____ EMPLOYER NAME: _____

SPOUSE: _____ YOUR ACTIVITY LEVEL: ☐ LOW ☐ MODERATE ☐ HIGH ☐ INTENSE

WOULD YOU LIKE APPOINTMENT REMINDERS? ☐ YES ☐ NO

IF YES, ☐ EMAIL ☐ TEXT TO CELL (SERVICE PROVIDER: _____)

YOUR HEALTH SUMMARY

Please ☑ check all symptoms you have ever had (s=self), even if they do not seem related to your current problem,
& mark (f=family) if you have a family history of any of them, like this ☑

S F		S F		S F		S F	
☐ ○	STROKE	☐ ○	EPILEPSY	☐ ○	HEADACHES	☐ ○	MOOD SWINGS
☐ ○	HEART ATTACK	☐ ○	HYPOGLYCEMIA	☐ ○	NECK PAIN	☐ ○	LOSS OF BALANCE
☐ ○	DIABETES	☐ ○	PACEMAKER	☐ ○	POOR SLEEP	☐ ○	NERVOUSNESS
☐ ○	THYROID DISEASE	☐ ○	ORGAN TRANSPLANT	☐ ○	DIZZINESS	☐ ○	STOMACH
☐ ○	GALLBLADDER DISEASE	☐ ○	HIGH BLOOD PRESSURE	☐ ○	HYSTERECTOMY	☐ ○	HAIR LOSS / THINNING
☐ ○	KIDNEY DISEASE	☐ ○	INTESTINE PROBLEMS	☐ ○	MID BACK PAIN	☐ ○	COLD FEET
☐ ○	DEPRESSION	☐ ○	SHORTNESS OF BREATH	☐ ○	LOWER BACK PAIN	☐ ○	HOT FLASHES
☐ ○	GOUT	☐ ○	HIGH CHOLESTEROL	☐ ○	CANCER (TYPE: _____)	☐ ○	HEARTBURN

List any medications you are taking & what for : _____

_____

In addition to weight loss, if there was one other health condition or struggle that you would love to see your body heal and/or

overcome, what would that be? _____

If "YES", please describe: _____

Are you under regular chiropractic care? ☐ **YES** ☐ **NO**

How long have you been overweight? _____ Have you tried to lose weight in the past? ☐ **YES** ☐ **NO**

What are your top 2 reasons why you want to lose weight, improve your health and thrive?   1. _____ 2. _____

Has your doctor recommended you to lose weight? ☐ **YES** ☐ **NO**

What is your "Goal Weight"? _____ When is the last time you weighed that? _____

On a scale of 1-10, with 10 meaning "I'M SERIOUS ABOUT LOSING WEIGHT AND FULLY COMMITTED" what is your current level of

commitment? **1   2   3   4   5   6   7   8   9   10**

Are you currently taking either, Insulin, Steroids, Estrogen or undergoing any Hormone Replacement Therapy? ☐**YES** ☐**NO**

FEMALES:

Are you pregnant? ☐ **YES** ☐ **NO**   Are you breast feeding? ☐ **YES** ☐ **NO**

Are you on birth control? ☐ **YES** ☐ **NO**   Do you have an estrogen patch or implant? ☐ **YES** ☐ **NO**

(PLEASE TURN OVER AND COMPLETE OTHER SIDE.)

HOW DID YOU FIND OUT ABOUT US?

PLEASE CHECK ALL THAT APPLY

☐ FRIEND/FAMILY _____

☐ BILLBOARD

☐ BROCHURE

☐ CURRENTLY A CHIROPRACTIC MEMBER

☐ NEWSPAPER _____

☐ NEWSPAPER _____

☐ NEWSPAPER _____

☐ FACEBOOK

☐ INTERNET: BING SEARCH

☐ INTERNET: GOOGLE

☐ INTERNET: YAHOO

☐ COUPON BOOK

☐ LOCATION