Weight Loss or Red Light Therapy New Client

1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married ○ Domestic Partner ○ Separated ○ Divorced ○ Widowed

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Email: _____

Occupation _____

Emergency contact name, phone number and relationship _____

Preferred contact method:
○ Mobile Phone ○ Home Phonel

If you have children, how many and what are their ages?

_____

HSA and FSA often cover our services, do you have one?
☐ Yes ☐ No

2. Weigth and height information

Your height: _____ Current weight: _____ Lowest adult weight: _____

Highest adult weight: _____ Desired weight: _____ Is your weight stable or up and down? _____

3. Were you referred to us by anyone (physician, friend, etc)? If yes, who? If no, how did you hear about us?

_____

_____

_____

_____

4. Have you ever consulted a professional (Nutritionist / Dietician) about your nutrition? If yes, when was that? Please describe what concerns you had in mind then and how effective the consultation was.

_____

_____

5. Are you under consistent chiropractic care?

○ Yes ○ No

6. Would you like to learn which supplements can improve your health?

☐ Yes ☐ No

7. Please list your top major health concerns in order of importance, and indicate date of diagnosis (where relevant):

	Concern	Date
1		
2		
3		

8. Please list 1 to 5 health goals you would like to attain for yourself, in order of priority:

	Goal
1	
2	
3	
4	
5	

9. What problem areas would you like addressed? Please check all that apply.

☐ Love Handles ☐ Wrinkles / Age Spots ☐ Flabby Arms
☐ "Mommy Tummy" ☐ Turkey Neck ☐ Thighs
☐ Back Fat ☐ Cellulite ☐ Scars / Stretch Marks

10. What habits, activities or attitudes do you consider to have contributed to any of your problems?

11. On a scale of 1-10, with 10 meaning "I'm serious and am fully committed," what is your current level of commitment?

12. What do you want to achieve during your initial consultation visit?

13. Are you taking any of these medications? (Check all that apply)

- ☐ Chemotherapy Pills (such as Hydroxyurea)
- ☐ Dabigatran (Pradaxa)
- ☐ Prasugrel (Effient)
- ☐ Apixaban (Eliquis)
- ☐ Ticagrelor (Brilinta)
- ☐ Blood Thinners (Including Baby Asprin)
- ☐ Heparin (Any)
- ☐ Anti-Coagulants
- ☐ Warfarin (Coumadin)
- ☐ N/A
- ☐ Anti-Platelet Agents
- ☐ Clopidogrel (Plavix)
- ☐ Rivaroxaban (Xarelto)
- ☐ Dipyridamole

14. Please list any non-prescribed medications you take (laxatives, antihistamines, decongestants, aspirin, tylenol, etc.):

	Type	How Often?
1		
2		
3		

15. Please list any prescribed medications you take:

	Name	Dosage	How long?
1			
2			
3			

16. Supplements now or in the recent past:

	Name of supplement	Dosage	Duration	Benefits	Side effects
1					
2					

17. Do you use recreational drugs? If yes, please specify type and frequency.

	Type	Frequency
1		
2		

18. Allergies or sensitivities (foods, medications, pollen, animals, chemicals):

19. Do you follow a specific diet?

- ○ No
- ○ Vegetarian
- ○ Vegan
- ○ Low Fat
- ○ Low Carb
- ○ High Fiber
- ○ Other

If "other", please specify

20. Eating patterns. Check all that apply:

- ☐ Eat too much
- ☐ Eat too little
- ☐ Forget to eat
- ☐ Emotional eater
- ☐ Eat out of boredom
- ☐ Hungry all the time
- ☐ Late night snacking
- ☐ Fast eater
- ☐ Eat in the car
- ☐ Poor choices
- ☐ Healthy choices
- ☐ No joy in eating
- ☐ Other

If "other", please specify

21. What do you consider healthy food choices?

22. What do you consider poor food choices?

23. Are you pleased with your present diet? What would you like to change?

24. Have you tried to make these changes?

25. Have you tried any popular diets? If yes, which ones and for how long? What could have made

them better?

26. How much water do you drink per day?

27. Do you drink coffee? If yes, how much per day?

28. Do you drink sodas? If yes, how much per day?

29. Do you drink alcohol? If yes, please specify:

How much alcohol do you consume per week?

Type of alcohol:

30. Smoking : Answer when applicable:

Do you smoke?
☐ Yes ☐ No ☐ I've quit

How much per day?

For how long?

When did you stop?

Do you work or live closely with a smoker?

31. Your activity level

Do you exercise regularly?
☐ Yes ☐ No

Type of exercise:

How often?

Length of sessions:

Do you sweat?
☐ Yes ☐ No

32. What level of stress do you consider yourself to be under?

○ Low ○ Moderate ○ High

33. How would you describe your bowel movement?

- ☐ Strained
- ☐ Loose
- ☐ Soft
- ☐ Hard
- ☐ Very thin
- ☐ Diarrhea
- ☐ Explosive
- ☐ Constipated
- ☐ Undigested food
- ☐ Blood in stool
- ☐ Mucus in stoll
- ☐ Regular
- ☐ Other

If "other", please specify

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34. Please list all surgeries you have had:

	Surgery	When?
1		
2		
3		

35. Health history - Musculo-skeletal

- ☐ Headaches
- ☐ Joint stiffness/swelling
- ☐ Broken/fractured bones
- ☐ Back pain
- ☐ Hip pain
- ☐ Leg pain
- ☐ Problems walking
- ☐ Chest, ribs, abdominal pain
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Bone or joint disease
- ☐ Other

If "other", please specify

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36. Health history - Skin

- ☐ Acne
- ☐ Cosmetic surgery
- ☐ Rashes
- ☐ Allergies
- ☐ Athlete's foot
- ☐ Warts
- ☐ Hives
- ☐ Other

If "other", please specify

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37. Health history - Reproductive system

- ☐ Hysterectomy
- ☐ Endometriosis
- ☐ Pelvic inflammatory disease
- ☐ PMS
- ☐ Menopause
- ☐ Fertility concerns
- ☐ Prostrate concerns
- ☐ Other

If "other", please specify

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38. Health history - Circulatory and respiratory

- ☐ Dizziness
- ☐ Shortness of breath
- ☐ Fainting

- ☐ Cold feet or hands
- ☐ Night sweats
- ☐ Swollen ankles
- ☐ Blood clots
- ☐ Stroke
- ☐ Heart condition
- ☐ Allergies
- ☐ Sinus problems
- ☐ Asthma
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Other

If "other", please specify

_____

39. Health history - Nervous system

- ☐ Spinal cord injury
- ☐ Chronic fatigue syndrome
- ☐ Numbness/tingling
- ☐ Twitching of face
- ☐ Fatigue
- ☐ Chronic pain
- ☐ Sleep disorders
- ☐ Ulcers
- ☐ Paralysis
- ☐ Herpes/shingles
- ☐ Cerebral palsy
- ☐ Epilepsy
- ☐ Multiple sclerosis
- ☐ Muscular dystrophy
- ☐ Parkinson's disease
- ☐ Other

If "other", please specify

_____

40. Health history - Digestive

- ☐ Nervous stomach
- ☐ Indigestion
- ☐ Constipation
- ☐ Intestinal gas
- ☐ Bloating
- ☐ Diarrhea
- ☐ Diverticulitis
- ☐ Crohn's disease
- ☐ Colitis
- ☐ Irritable bowel
- ☐ Food allergies
- ☐ Other

If "other", please specify

_____

41. Health history - Other

- ☐ Migraine
- ☐ Cancer
- ☐ Loss of appetite
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Hearing impaired
- ☐ Visually impaired
- ☐ Bladder infection
- ☐ Eating disorder
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Infectious disease
- ☐ Anxiety
- ☐ Thyroid Disease
- ☐ Other

If "other", please specify

_____

42. How would your life change if you did not have the problems listed on this form?

_____

_____

_____

_____

43. Feel free to use the space below to inform us of any extra information pertinent to your health: