blueprint to Weight Loss

PERSONAL INFORMATION

Name _____ **Date** _____

Address _____

City _____ **State** _____ **Zip** _____

Phone *(Home)* _____ *Mobile* _____

Email _____ **Date of Birth** _____

Age _____ **Height** _____ **Occupation** _____

Who may we thank for referring you to our office?

Friend or Family _____ **Health Care Provider** _____

Online Search _____ **Wellness Class** _____ **Other** _____

MEDICAL HISTORY

Do you or any family member have/had any of the following? Please put an "X" for you, and "F" for family

☐ Depression	☐ Brain fog	☐ Headache
☐ Heart Attack	☐ Hypoglycemia	☐ Neuropathy/nerve problems
☐ Diabetes	☐ Anemia	☐ Poor Sleep
☐ Thyroid Disease	☐ Cancer	☐ Dizziness
☐ Gallbladder Disease	☐ High Blood Pressure	☐ Arthritis
☐ Kidney Disease	☐ Intestine Problems	☐ Weight gain
☐ Stroke	☐ Shortness of Breath	☐ Back Pain
☐ Fatigue	☐ High Cholesterol	☐ Carpal Tunnel

Is there a certain time of day any of these problems are better or worse? _____

_____

Are you taking any medications/supplements? _____ If Yes, please list _____

_____

Are you pregnant? _____ How many children? _____ How many pregnancies? _____

Are you breast feeding? _____

Any known allergies? _____ If Yes, please list _____

_____

Main Concerns:

1. _____ 2. _____
3. _____ 4. _____

How long have you had this/these concerns? _____

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What effect does this have on your body functions or quality of life? _____

_____

What would be different or better without this/these concerns?

☐ Diminished Stress ☐ More Energy ☐ Improved Self-Esteem ☐ Confidence ☐ Sleep

☐ Work ☐ Family ☐ Outlook

How have you addressed weight management in the past?

☐ Medications ☐ Vitamins ☐ Exercise ☐ Diet and Nutrition ☐ Other _____

How did the previous methods work for you? _____

What potential barriers do you foresee that would prevent the change you are looking for?

_____

_____

Do you feel it possible to eliminate or prevent these potential barriers? _____

What outcome would you like to see for this to be a success for you? _____

_____

_____

Please rate on a scale of 1-10 (1 being the lowest and 10 being the highest)

Energy Level	1	2	3	4	5	6	7	8	9	10
Quality of Sleep	1	2	3	4	5	6	7	8	9	10
How Important It Is For You To Resolve Your Health Concerns	1	2	3	4	5	6	7	8	9	10
What Is Your Level of Preparedness To Make Necessary Lifestyle Changes To Achieve Your Goals?	1	2	3	4	5	6	7	8	9	10

I am interested in:

Weight loss ☐ ***Inch Loss*** ☐ ***Anti-Aging*** ☐ ***Metabolism Support*** ☐

Long Term Results ☐