"ChiroThin: 6 Week Weight Loss Program

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PATIENT INTAKE FORM

Name: _____ Date Of Birth: _____ Date: _____
(LAST, FIRST) **(MM/DD/YEAR)** **(MM/DD/YEAR)**

Address: _____ City: _____ Postal code: _____

Cell Phone: _____ Home Phone: _____ Email Address: _____

How did you find out about our weight loss program? _____

Do you experience any of the following even if they are minor and go away on their own?

____ High Blood Pressure	____ *Diabetes*	____ *Hypoglycemia*	____ *Gall Bladder Disease*
____ *Active Cancer*	____ Heart Disease	____ Thyroid Problems	____ Digestive Disturbance
____ Hormonal Change	____ Kidney Disease	____ Bloating	____ Fibromyalgia
____ Joint Pain/Arthritis	____ Numbness	____ Osteoporosis	____ Sinus/Allergy
____ Stress/Irritability	____ Inflammation	____ Alcohol	____ Smoking
____ Headaches	____ *Pregnant*	____ Chronic Fatigue	____ Take Drugs/Marijuana
____ Depression	____Eating Disorders	_____ Food Allergies	

Other: _____

Present Weight: _____ Height: _____ Desired Weight: _____ Weight one year ago: _____

Does your family support your weight loss efforts? _____

Are your parents obese? _____ Is your partner overweight? _____

Why do you currently want to lose weight? _____

Have you taken appetite suppressants before? YES / NO Do you currently take nutritional supplementation? YES / NO

How long have you struggled with your weight? _____

Have you tried other weight loss plans and if so, what have you tried? _____

What were your results? _____ How long did you keep the weight off? _____

Do you have any other health challenges important for us to know about? _____

Is there anything that will interfere with your weight loss? _____

Do you drink tea, coffee, cola? YES / NO How much per day? _____

Do you eat out? YES / NO How many times a week? _____

Describe your usual energy level: _____

Do you use food under stressful situations? _____

MY PERSONAL DECLARATION

Name: _____ Date: _____
(LAST, FIRST) **(MM/DD/YEAR)**

I consent for treatment and guidance while on this program. I will follow the program designed or modified by the ChiroThin supervising health provider. I agree to attend all scheduled weekly appointments. I also understand that up to 6 appointments are included in the price of the entire program. I understand that the payment is to cover the costs of the Supervision, program and supplies.

_____ **(Patient Initials)** _____ **(Doctor Initials)**

I agree to the following:

- I will eat every component of every meal as described.
- I will not skip any meals.
- I will take my sprays as scheduled and will not miss taking them.
- I will not drink soda or diet soda.
- I will not drink alcohol.
- I will fill out my daily journal to be reviewed at the weekly sessions.
- I will drink my daily amount of prescribed water.
- In order to achieve my desired goals, I agree not to quit or give up. I will be honest with myself and agree **NOT TO DO** things that are not in alignment with the program.

_____ **(Patient Initials)** _____ **(Doctor Initials)**

I understand that once I have started my weight loss program there are **NO** refunds. I also understand that my program is **NON** transferable.

_____ **(Patient Initials)** _____ **(Doctor Initials)**

I understand that I undertake this program entirely at my own free will and risk and that my doctor will endeavor to take all due care. I understand that my doctor will rely on statements made by me to determine that the procedure is safe and effective for me. I have informed the physician of all known physical and medical conditions, and medications. I assume all responsibility and liability for any condition(s) I have failed to disclose. I choose to do this of my own free will.

_____ **(Patient Initials)** _____ **(Doctor Initials)**

I will not hold anyone responsible except for myself while undertaking this program. I am solely responsible for the outcome of the program.

Name: (Signature): _____ Witness: (Signature): _____