Mountain View CHIROPRACTIC

A B C D

Patient Intake Form

Contour Light

Your success is our #1 priority.
Help us to help you achieve that success by filling out this questionnaire as completely as possible.

Name: _____ Date: _____

Address: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____ Height: _____ Weight: _____

Age: _____ Sex: _____

Are you currently under the care of a physician? _____

Do you exercise? _____ How often? _____ What type? _____

What do you expect from your Contour Light treatment? _____

_____

If you were referred by one of our former clients, please tell us who we can send

a Thank You note to: _____

Weight Loss

How much weight have you decided to lose? _____

What methods failed to help you lose weight? _____

_____

Do you feel tired, run down, and out of energy? _____

Do you have any pain in your back, neck, shoulder, knees or hips? _____

_____

Areas of Your Body That You Want to Change