CHIROWELL
LIVE WELL

Weight Loss Intake Form

Patient Name : _____ Date :_____

Street : _____ City : _____ State :_____Zip : _____

Cell Phone : _____ Email :_____

Date of Birth :_____ Age: _____ Marital Status:_____

Occupation :_____

Do you have children? □ Yes □ No If so, when was your last pregnancy?:_____

Referred by:_____

Family Physician:_____

Concurrent Health Therapies or Regimens: _____

Height: _____ Weight:_____ Ideal Weight:_____

How long have you struggled with your weight?_____

Previous Weight Programs:_____

Results:_____

Are you more interested in losing: Inches:_____ Pounds:_____

Most recent car accident?_____

HSA (Health Savings) and FSA (Flex Spending) cover our services, do you use either of these?

□ Yes □ No If yes, please list:_____

Please select any of the following conditions that apply to you:

Pain Indicators

□ Headaches □ Neck pain □ Shoulder pain □ Upper back pain □ Mid back pain □ Low back pain

□ Hip pain □ Radiating leg pain □ Knee pain □ Ankle pain □ Radiating arm pain □ Wrist pain

Body Composition

□ Love Handles □ Wrinkles/Age Spots □ Flabby arms □ Mommy tummy □ Turkey Neck □ Back fat

□ Cellulite/Stretch Marks □ Stomach □ Hips □ Outer thighs □ Inner thighs

Lifestyle

□ Stress □ Caffeine □ Undereating □ Overeating □ Skipping meals □ Excessive sugar/carbs □ Low Activity

□ Poor Sleep □ Nerves □ Alcohol □ Poor liver □ Large appetite

Medical History

□ Acid Reflux □ ADD □ Allergies □ Anxiety □ Arthritis □ Asthma □ Cancer □ Diabetes □ Epilepsy

□ Fatigue □ Heart Disease □ Hepatitis □ High Blood Pressure □ High Cholesterol □ Infertility □ Insomnia

□ Joint Pain □ Kidney Disease □ Liver Disease □ Seizures □ Sleep Apnea □ Surgeries □ Significant Trauma

□ Thyroid Disease □ TMJ □ Ulcers □ Vertigo □ Weight Problems

List medications/prescriptions:_____

List vitamins/minerals/supplements:_____

Do any family members have any of the following health conditions? If so please indicate.

□ Acid Reflux □ ADD □ Allergies □ Anxiety □ Arthritis □ Asthma □ Cancer □ Diabetes □ Epilepsy

□ Fatigue □ Heart Disease □ Hepatitis □ High Blood Pressure □ High Cholesterol □ Infertility □ Insomnia

□ Joint Pain □ Kidney Disease □ Liver Disease □ Seizures □ Sleep Apnea □ Surgeries □ Significant Trauma

□ Thyroid Disease □ TMJ □ Ulcers □ Vertigo □ Weight Problems

Patient Signature:_____

To be filled by Medical Provider

Section	Initial Measurement	Second Measurement
Arm (R)		
Arm (L)		
Leg (R)		
Leg (L)		
Stomach (Upper)		
Stomach (Mid)		
Stomach (Lower)		