New Patient Intake Form

Weight Loss

Basic Patient Information

Name:	**Date:**
Street Address:	
City:	**State:** **Zip:**
Home Phone:	**Cell Phone:**
Email Address:	
Sex: M | F **Age:** **Birth Date:**	**Height:** **Weight:**
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced	
Occupation:	**Hobby:**
How did you hear about us?	

Health and Wellness History

Are you currently under the care of a physician? ☐ YES ☐ NO
Are you currently taking any medication? ☐ YES ☐ NO
Has your Doctor advised you to lose weight? ☐ YES ☐ NO
Do you have any dietary restrictions? ☐ YES ☐ NO **If so, please explain:**
How often do you exercise? ☐ YES ☐ NO **If so, what type?**
Do you feel stressed? ☐ YES ☐ NO
Check ALL that apply to you: ☐ Heart Condition ☐ Epilepsy/Seizures ☐ Pregnant ☐ Might be pregnant ☐ Taking heart medication/blood thinners ☐ Undergoing chemotherapy ☐ Breast feeding ☐ Known adverse reactions to Niacin or B vitamins
PLEASE CONTINUE TO THE FOLLOWING PAGE

New Patient Intake Form

Weight Loss & Body Contouring

FOR THIS NEXT SECTION PLEASE ANSWER THE FOLLOWING QUESTIONS HONESTLY SO WE CAN DO OUR BEST TO HELP YOU REACH YOUR GOALS.

Check ALL areas of treatment that interest you:

☐ Weight Loss ☐ Cleansing and Detoxification ☐ General Wellness ☐ Body Wraps ☐ More Energy ☐ Stress Reduction ☐ Other
Did you know that all treatments above are 100% safe? ☐ YES ☐ NO
Have you ever used any of the treatments above? ☐ YES ☐ NO
What do you consider to be your ideal weight?
How much weight do you want to lose?
How many times a year do you diet?
What is stopping you from losing weight on your own? **Please explain:**
What have you tried in the past that failed? **Please explain:**
Does your weight problem make you physically uncomfortable? ☐ YES ☐ NO **If yes, please explain:**
Does your weight problem cause physical pain? ☐ YES ☐ NO **If yes, please explain:**
Are you embarrassed by your excessive weight? ☐ YES ☐ NO **If yes, please explain:**
Does being overweight and unhealthy limit your activities? ☐ YES ☐ NO
Do you binge eat? ☐ YES ☐ NO
Do you suffer from uncontrollable cravings? ☐ YES ☐ NO
Do you feel that food controls you? ☐ YES ☐ NO
Do you eat because of your emotions? ☐ YES ☐ NO

Do you eat between meals? ☐ YES ☐ NO
What do you choose to eat between meals?

Briefly describe your daily eating behaviors:
Do you feel that your eating behaviors are normal? ☐ YES ☐ NO
Do you feel tired, run down, or out of energy? ☐ YES ☐ NO
Is successful weight loss a top priority? ☐ YES ☐ NO
How fast do you want to be slim, trim, and fit?
What's more important to you: fast or permanent?
Does your family support your weight loss efforts? ☐ YES ☐ NO
Is your family excited that you're working with us? ☐ YES ☐ NO
Can you remember being at your ideal weight? ☐ YES ☐ NO **Please describe what it was like being at your ideal weight:** **ONCE THIS FORM HAS BEEN COMPLETED PLEASE RETURN IT TO THE FRONT DESK.**

During this treatment and consultation, you will be receiving:

- Body Contouring Treatment(s)
- V.I.B Session(s)
- Complete Body Composition Analysis
- Weight Loss & Body Contouring Consultation with our Expert Staff.
- Nutrition Consultation

Please fill out the new patient paperwork and bring it with you, if not please arrive about 10 minutes early to your scheduled time to fill out our short new patient paperwork and to meet our amazing team.

Here's Our Recommended Steps Prior to Your Visit to Obtain Optimal Results:

- Drink 8 glasses of water the day before and 2 glasses of water prior to your appointment.
- Reduce carbohydrate consumption 24 hours before.
- Recommended no alcohol 24 hours before appointment.
- Women are asked to wear bikini-style bra and underwear for treatment.
- No makeup or lotions.
- Refrain from eating about 1 hour before your visit.

Do to the high volume of appointment requests we require a 48 hour notice for any rescheduled appointments by phone or text only to the number below.

Any missed appointments without notification will result in missing that session in your package.