VIBRANTHEALTH
nourish · revitalize · transform

WEIGHT LOSS NEW PATIENT INTAKE

Patient Name: _____ DOB: _____

Mailing Address: _____

City, State, Zip: _____

Phone: Cell_____ Home _____ Work _____

Email: _____
Would you like to receive our clinic newsletters? Yes / No

List all food and/or medicine allergies: _____
_____
_____

List any medical conditions you are currently being treated or evaluated for: _____
_____
_____
_____

List all <u>medications</u> with dosages and what condition you are taking them for: _____
_____
_____
_____

List all <u>supplements</u> you are currently taking or that have been prescribed: _____
_____
_____
_____

When was your last physical examination by your primary care doctor? _____
Have you had blood work done within the last 12 months? Yes / No
If yes, please list what tests you had and the results. _____
_____
_____
(We require copies of most recent blood work for our records).

Have you had a colonoscopy within the past 5 years? Yes / No If yes, were there any abnormal findings? _____

WOMEN ONLY:
Have you had a mammogram or breast thermography within the past year? Yes / No
Have you had a bone scan within the past 5 years? Yes / No
Do you suffer from menopausal symptoms? Yes / No
Do you suffer from PMS? Yes / No
Approximately, when was your last menstrual cycle? _____
How many children have you given birth to? _____

MEN ONLY:
Have you had a prostate exam? Yes / No
Do you have any urinary frequency/urgency or difficulty initiating urination? Yes / No

WEIGHT HISTORY:
What is your height? _____ feet _____inches
What is the most you have ever weighed? _____
The least you have weighed as an adult? _____
Current weight? _____
Over the past year have you (circle one):
_____ Gained Weight _____Lost Weight _____ Maintained Weight
What is your ideal goal weight? _____

Are you currently attempting to get pregnant? Yes / No
Pregnant? Yes / No
Breastfeeding? Yes / No

FAMILY HISTORY: (Check all that apply)
_____Cancer _____Diabetes _____Heart Disease/Heart Attack _____High Blood Pressure
_____Kidney Disease _____Liver Disease _____Obesity _____Stroke _____Gout
_____Depression

Other family history: _____
_____
_____
Please list all surgeries and/or hospitalizations you have had including approximate month/year and reason for the surgery or hospitalization: _____
_____
_____
_____
_____
Please list any significant past or current health issue or illnesses including approximate dates:
_____
_____
_____
_____

Is there a particular event you are preparing for? Yes / No

If yes, what is the event and when is it? _____

What diets have you tried in the past and what were the results? _____
_____
_____
_____
_____
_____

HEALTH HABITS:

Do you smoke? _____Never _____Not in past 5 years _____Not in past 20 years _____ Yes, Currently
If yes, how many packs/week? _____
Do you consume alcohol? If yes, how many drinks/day/week? _____
Do you drink sodas of any kind? Yes / No How many? _____ How often? _____
Do you drink coffee? Yes / No How many cups/day? _____
How many glasses of water do you drink/day? _____
Do you eat breakfast? Yes / No
Do you skip meals? Yes / No
In your typical day, when are you the most hungry? _____
Do you eat/purchase your meals out more than 3x/week? Yes / No If yes, how many days? _____
What foods do you crave? _____
What are your favorite foods? _____
_____
Do you suffer from any digestive issues after eating any particular food? Yes / No
If yes, which foods_____
_____
Are you an emotional eater? Yes / No If yes, explain: _____
_____
Do you have a tendency to binge eat? Yes / No If yes, explain _____
_____

EXERCISE:

Daily Activity Level: **(**Circle one) Sedentary 1 2 3 4 5 6 7 8 9 10 Very Active
How often do you exercise? (Check one)
_____ 1x/week _____2 – 3x/week _____3 – 4x/week _____More than 5x/week
What type of physical activity do you do? (Check off all that apply):
_____ Cardio _____ Strength Training _____ Exercise _____ No activity _____ Other
Do you have a physical condition that limits your exercise activity? If so what is that limitation?
_____
_____

GENERAL WELLNESS:

Stress Level: (Circle one) Total Relaxation 1 2 3 4 5 6 7 8 9 10 Extreme Stress
Are your bowel movements regular? Yes / No
Do you suffer from constipation? Yes / No Diarrhea? Yes / No How often? _____
_____
How often do you have a bowel movement? _____
_____

Do you suffer from fatigue or loss of motivation? If so, please explain how it impacts your daily life?

_____

Do you believe you may be depressed? Yes / No

How many hours do you sleep every night? _____ Do you feel it is enough? Yes / No

Do you suffer from pain anywhere? If so, please be specific about where the pain is and when it started:

_____

_____

_____

What is your primary motivation for losing weight? _____

_____

_____

How motivated are you now compared to previous attempts to lose weight? _____

_____

_____

Why do you feel you have had difficulties losing weight? _____

_____

_____

Do you believe your friends or family members will be supportive of your weight loss? _____

_____

_____

What do you think will be the hardest part about doing this program? _____

_____

_____

Do you foresee any challenges arising while you are on this program? (ie, social events, holidays, lack of family support, work environment, etc.) _____

_____

_____

In addition to the HCG Therapy Program, we offer a variety of other services through our family Naturopathic practice. Please check off any services that you would like to learn more about:

_____ Naturopathic Care for Adults & Children
_____ Bio-Identical Natural Hormone Therapy
_____ IV Vitamin and Chelation Therapy
_____ NutrEval Blood Testing – whole body test including vitamin & mineral status
_____ Food sensitivity/Allergy testing
_____ Evaluation and Testing for Lyme Disease
_____ Neurotransmitter Testing
_____ Detoxification & Cleansing Programs
_____ Breast & Full Body Thermography
_____ Natural treatments to improve sleep
_____ Natural treatments to improve memory and focus
_____ Natural Foot Care
_____ Emotional Freedom Technique
_____ NeuroFeedback

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HIPAA CONSENT FORM

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Patient Name: _____ DOB: _____
Signature: _____ Date: _____
Patient, parent, or legal guardian

If signed by other than patient state relationship to patient: _____