KARE
CHIROPRACTIC
"Because We Care About Your Health"

Weight Loss Evaluation Paperwork

Please complete this form to the best of your ability. If you need help our receptionist will gladly assist you!

Today's Date:_____

Legal Name : _____ Date of Birth: _____ Age: _____

Preferred Name: _____ Sex: ☐ Female ☐ Male

Race: ☐ White ☐ African American ☐ Hispanic ☐ Other: _____

Address: _____

City: _____ State: _____ ZIP: _____

Cell Phone: _____ Home Phone: _____

Social Security Number: _____ Height: _____ Weight: _____

Email: _____

Employer: _____ Occupation: _____ Phone: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Do you give us permission to contact this person in the event of an emergency? ☐ Yes ☐ No

How did you hear about our office? _____

Primary Care Physician: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Allergies

☐ Penicillin	☐ Morphine	☐ Dye Allergies	☐ Codeine
☐ Aspirin	☐ Nitrate Allergy	☐ Seasonal (Pollen)	☐ Sulfa Drug
☐ Food Allergies	☐ Other: _____		

Please describe allergic reaction you experienced and when it occurred: _____

_____

_____

Medical Conditions and Diseases

Please check all personal history that applies to you:

☐ Diabetes	☐ Osteoporosis	☐ High Blood Pressure	☐ High Cholesterol
☐ Heart Disease	☐ Cancer	☐ Kidney Disease	☐ Liver Disease
☐ Thyroid Disease	☐ Anemia	☐ Smoker	☐ Fibromyalgia

☐ Nausea/Vomiting ☐ Acid Reflux ☐ Diarrhea ☐ Constipation

☐ Ulcers ☐ IBS ☐ Diverticulitis ☐ Crohns/IBD

☐ PCOS ☐ Chronic Fatigue ☐ Currently Pregnant ☐ Birth Control

Other (Please List): _____

Family Medical History (Please List): _____

_____

_____

Current prescription medications, vitamins, and supplements(including nutritional/protein supplements) you are presently taking (Please list all including OTC, herbs, ect): _____

_____

_____

_____

Diet and Lifestyle History

Roughly how many ounces of water do you drink daily: _____

How many meals do you usually eat per day? _____ Do you skip meals? ☐ Yes ☐ No

Do you eat out? ☐ Yes ☐ No Are you a binge eater: ☐ Yes ☐ No

Have you ever had bulimia or anorexia disorder? ☐ Yes ☐ No

Please list food cravings: _____

Are you currently participating in any specific diet? ☐ Yes ☐ No If yes, Please explain: _____

_____

Please list diets/medications you have used for weight loss in the past: _____

_____

Do you exercise? ☐ Yes ☐ No If yes, how often and what types of exercises: _____

_____

Is your job activity primarily: ☐ Sedentary ☐ Light ☐ Moderate ☐ Heavy

Do you use:

Alcohol ☐ Yes ☐ No How many drinks and how often? _____

Tobacco ☐ Yes ☐ No How many and how often? _____

Caffeine ☐ Yes ☐ No How much and how often? _____

Patient Questionnaire

How much weight are you wanting to lose? _____

Please list any symptoms you are experiencing:

☐ Stress ☐ Sudden Weight Gain ☐ Sudden Weight Loss ☐ Insomnia

☐ Lack of energy ☐ Night Blindness ☐ Depression ☐ Diarrhea

☐ Dry skin ☐ Decreased appetite ☐ Fatigue ☐ Nosebleeds

☐Cold hands/feet	☐ Muscle Pain	☐ Chronic Pain	☐ Constipation
☐ Fluid retention	☐ Tingling fingers/toes	☐ Numbness	☐ Memory Loss
☐ Trouble Breathing	☐ Reoccuring Infections	☐ Light Sensitivity	☐ Nervousness
☐ Decreased Sex Drive	☐ Brittle Nails	☐ Hair loss	☐ Headache
☐ Nausea/Vomiting	☐ Skin Rashes	☐ Irritability	☐ Mood
☐ Increased grey hair	☐ Confusion	☐ Dizziness/lightheadedness	☐ Cramps
☐ Decreased alertness	☐ Stiff Muscles	☐ Altered taste/smell	☐ Gingivitis
☐ Shortness of breath	☐ Increased bleeding	☐ Easy bruising	

☐ Other: _____

Consultation for Medical Weight Loss Services

I understand that my initial consultation is complementary and is used to determine whether or not I am a candidate for medical weight loss.

The only cost I may incur is the cost of any initial screening tests the Doctor requests, that I choose, to undergo.

I am aware that after the consultation, I may not be accepted as a patient or additional testing may be recommended. Whether or not I am accepted as a patient, I will receive a copy of any laboratory results.

I agree to fill out all paperwork completely to the best of my knowledge.

I understand that I am encouraged to communicate with my other health care providers about all of my health care, including care I receive at this office.

By signing below, I agree that I have read, understand and accept the terms of the complimentary consultation.

Patient Name(Print): _____

Patient Signature(X): _____ **Date:** _____

I have been offered and understand the **Patient Health Information Consent Form.**

I have been offered and understand the **Missed Appointment Policy** and the **$50 fee** associated.

Patient Signature(X): _____ **Date:** _____