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(*required*): _____

***Email is used for secure patient portal communication, online scheduling, and electronic statements.***

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 acknowledge and agree to the **Patient Health Information Consent Form**.*

I acknowledge and agree to the **Missed Appointment Policy** including the **$50** missed appointment fee.*

***Policies are available on the clipboard for review.***

**Patient/Parent/Guardian Signature(X):** _____ **Date**: _____