New Life Body Sculpting
New body, new look, new life!

PATIENT INTAKE FORM

Please print

Patient Data: _____

Legal Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Date of Birth _____ Age: _____

Martial Status (Circle one): Married Divorced Single Widow

Sex (circle one): Male Female

Email Address: _____

Employer: _____ Occupation: _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Do you experience any of the following even if they are minor and go away on their own? (Check all that apply)

___ High Blood Pressure	___ Diabetes	___ Hypoglycemia	___ Gall Bladder Disease
___ Active Cancer	___ Heart Disease	___ Thyroid Problems	___ Digestive Disturbance
___ Hormonal Change	___ Kidney Disease	___ Bloating	___ Fibromyalgia
___ Joint Pain/Arthritis	___ Numbness	___ Osteoporosis	___ Sinus/Allergy
___ Stress/Irritability	___ Inflammation	___ Alcohol	___ Smoking
___ Headaches	___ Pregnant	___ Chronic Fatigue	___ Take Drugs/Marijuana
___ Depression	___ Eating Disorders (please list) _____		___ Food Allergies

Other: _____

Present Weight: _____ Height: _____ Desired Weight: _____ Weight One Year Ago: _____

Does your family support your weight loss efforts? _____

Are your parents obese? _____ Is your partner overweight: _____

Why do you currently want to lose weight? _____

Have you taken appetite suppressants before? YES NO Do you currently take nutritional supplements? YES NO

How long have you struggled with your weight? _____

Have you tried other weight loss plans? If yes, what have you tried? _____

What were your results? _____ How long did you keep the weight off? _____

Do you have any other health challenges important for us to know? _____

Is there anything that will interfere with your weight loss? _____

Do you drink tea, coffee, cola? YES NO How many per day? _____

Do you eat out? YES NO How many times per week? _____

Describe your usual energy level: _____

Do you use food under stressful situations? _____

PATIENT HISTORY

Have you been treated by a medical physician for any condition this year? YES NO

Please list all doctors you have seen for any reason: _____

_____

_____

Please list all surgeries and/or dates of hospitalization: _____

_____

_____

Please list all prescription medications you are taking and why: _____

_____

_____

Are you allergic to any medication? If so, which ones? _____

Please list all supplements or over-the-counter medications you are taking such as vitamins or ibuprofen: _____

_____

_____

Please circle any habits listed: _____

Alcohol Chocolate Cigarettes Coffee Tea Sugar/Sugar Substitutes Laxatives

Are you pregnant? YES NO If yes, when are you due? _____

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DIETARY PREFERENCES

The purpose of this survey is to discover what you usually eat and drink five days a week, not including weekends. The spaces below will help you record your dietary habits. Please be specific when indicating your food choices.

Morning Meal

1. Do you usually eat breakfast (five days a week)? Yes No

2. When you have breakfast, is it at home? Yes No

   If not, where? Restaurant Fast Food Cafeteria

3. Do you use a meal substitute, such as Slim-Fast, etc? Yes No If yes, which one? _____

Mid-Morning Snacks: _____

Mid-day Meal

1. Do you usually eat lunch (five days a week)? Yes No

2. Do you usually eat lunch at home? Yes No

   If not, where? Carry Lunch Restaurant Fast Food Cafeteria

3. Do you use a meal substitute, such as Slim-Fast, etc? Yes No If yes, which one? _____

Mid-afternoon Snacks: _____

Evening Meal

1. Do you usually eat an evening meal (five days a week)? Yes No

2. When you have dinner, is it at home? Yes No

   If not, where? Restaurant Fast Food Cafeteria

3. Do you use a meal substitute, such as Slim-Fast, etc? Yes No If yes, which one? _____

Evening Snacks: _____

Other Dietary Items

1. Do you chew gum? Yes No

2. Do you use breath mints? Yes No

3. Additional food items not listed:

4: Any specific foods you crave: _____

   If so, is it on a certain day or time? _____

_____ _____

Patient Signature *Date*