Natural Health Solutions

A Family Wellness Center

Welcome To Our Clinic! Please Fill Out The Following Information Thoroughly So The Doctor Can Let You Know If You Are A Case We Can Accept. Please Feel Free To Ask Any Questions If You Need Assistance. We Look Forward To Serving You!

Name: _____ Date:_____

Address: _____

City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Birth Date: _____ Marital Status S M D W

How Were You Referred To This Office: _____

Are you in good health at the present time to the best of your knowledge? Yes No

Are you under a doctor's medical supervision at this time? Yes No
If yes, for what? _____

Are you taking any medications at the present time? Yes No
If yes, what medications? _____
_____

History of high blood pressure? Yes No

History of diabetes? Yes No

History of frequent headaches or migraines? Yes No
If yes, how often? _____ Medication? _____

History of constipation? Yes No

Serious injuries? Yes No
Details: _____

Surgeries? Yes No
Details:_____

Do weight problems run in your family? Yes No
If Yes, who? _____

Do you have a family history of:

- Diabetes? If Yes, who? _____
- Heart Disease? If Yes, who? _____
- Cancer? If Yes, who? _____
- Stroke? If Yes, who? _____

Nutritional Evaluation:

Present Weight: _____ Height: _____ Desired Weight:_____

When would you like to be at your desired weight?

Why do you want to lose weight? (Health Benefit? Appearance?) Please explain thoroughly:

_____
_____

When did you begin gaining weight? _____
Reason why? _____

What has been your maximum weight (non-pregnant) and when? _____

Have you tried other weight loss program? Yes No
If yes, which ones? _____

Were you successful with it / were you able to keep the weight off? Yes No
Please explain: _____

Is your spouse, fiancée or partner overweight? Yes No
By how much is he/she overweight? _____

How often do you eat out? _____

What restaurants do you frequent? _____

How often do you eat "fast foods"? _____

Food allergies:_____

Food dislikes:_____

Food cravings:_____

Do you drink coffee or tea? Yes No If yes, how much daily? _____

Do you drink pop / soft drinks? Yes No If yes, how much daily? _____

Do you drink alcohol? Yes No
What? _____ How much? _____ Weekly? _____

Do you use sugar substitutes? Yes No
If yes, what? _____

What are your worst food habits? _____
_____

Snack habits:
What:_____
How Much:_____
When:_____

When there is increased stress in your life, do you tend to eat more? Yes No
Explain:_____

Do you smoke? Yes No
If yes, how much? _____

Typical Breakfast:
What: _____
When:_____

Typical Lunch:
What:_____
When:_____

Typical Dinner:
What:_____
When:_____

Describe your energy level? _____

Activity level: (check one)
_____ Inactive
_____ Light activity
_____ Moderate activity
_____Heavy activity
_____Vigorous activity

On a scale of 1 to 10 with 10 being **MOST** committed, how committed are you to taking action and making a change in your life today? 1 2 3 4 5 6 7 8 9 10

_____ _____
Patient Signature: Date: