

Weight Loss & Wellness Intake Form

1. PERSONAL INFORMATION

Name: _____ Date of Birth: _____ Age: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone (Home): _____ (Mobile): _____
 Email: _____ Occupation: _____

Who may we thank for referring you to our office?

☐ Friend / Family ☐ Health Care Provider ☐ Online Search ☐ Wellness Class ☐ Other: _____

2. MEDICAL HISTORY

Do you or any family member have/had any of the following? Please put an "X" for you, and "F" for family.

You	F	☐ ☐ Depression	You	F	☐ ☐ Brain Fog	You	F	☐ ☐ Headache
☐	☐	Heart Attack	☐	☐	Hypoglycemia	☐	☐	Poor Sleep
☐	☐	Diabetes	☐	☐	Anemia	☐	☐	Dizziness
☐	☐	Thyroid Disease	☐	☐	Cancer	☐	☐	Arthritis
☐	☐	Gallbladder Disease	☐	☐	High Blood Pressure	☐	☐	Weight Gain
☐	☐	Kidney Disease	☐	☐	Intestine Problems	☐	☐	Back Pain
☐	☐	Stroke	☐	☐	Shortness of Breath	☐	☐	Carpal Tunnel
☐	☐	Fatigue	☐	☐	High Cholesterol	☐	☐	Neuropathy / Nerve Problems
						☐	☐	Other: _____

3. MEDICATIONS, SUPPLEMENTS & ALLERGIES

Are you taking any medications or supplements? ☐ Yes ☐ No

If yes, please list (include dose if known):

Any known allergies? ☐ Yes ☐ No

If yes, please list: _____

Are you pregnant? ☐ Yes ☐ No

Are you breast feeding? ☐ Yes ☐ No

How many children? _____ How many pregnancies? _____

4. CURRENT HEALTH CONCERNS

Main concerns (please list up to 4):

1. _____
 2. _____
 3. _____
 4. _____

How long have you had this/these concern(s)?

Is there a certain time of **day** any of these problems are better or worse?

Date: _____

Weight Loss & Wellness Intake Form

Page 2 of 4

5. WEIGHT MANAGEMENT HISTORY

How have you taken care of your health/weight management in the past? (Check all that apply)

- | | |
|---|--|
| ☐ Medications | ☐ Emergency Room |
| ☐ Vitamins / Supplements | ☐ Wellness Program / Class |
| ☐ Exercise | ☐ Weight Loss Program |
| ☐ Diet and Nutrition | ☐ Red Light Therapy |
| ☐ Chiropractic Care | ☐ Nutrition/Diet Counseling |
| ☐ Holistic Care | ☐ Other: _____ |
| ☐ Routine Medical Care | |

How did the previous method(s) work for you? (Check all that apply)

- | | |
|--|---|
| ☐ Great results | ☐ Did not work very long |
| ☐ Some results | ☐ Still trying |
| ☐ Bad results | ☐ Confused |
| ☐ Nothing changed | ☐ Other: _____ |
| ☐ Did not get worse | |

6. CURRENT IMPACT ON DAILY LIFE

What effect does this have on your body functions or quality of life? (Check all that apply)

- | | |
|--|--|
| ☐ Low energy / fatigue | ☐ Affects my mental health |
| ☐ Poor sleep | ☐ Limits exercise / physical activity |
| ☐ Difficulty with daily activities | ☐ Affects social life |
| ☐ Decreased motivation | ☐ Affects my overall happiness |
| ☐ Affects my work / job performance | ☐ Increases stress or anxiety |
| ☐ Affects my family / relationships | ☐ Limits my independence |
| ☐ Affects my self-esteem | ☐ Other: _____ |

How have others been affected by your health condition? (Check all that apply)

- | |
|---|
| ☐ No one is affected |
| ☐ Haven't noticed any problem |
| ☐ They tell me to do something |
| ☐ People avoid me |
| ☐ My family is concerned |
| ☐ Affects my kids |
| ☐ Other: _____ |

7. AREAS OF CONCERN & POTENTIAL RISKS

What are you most concerned with regarding your health? (Check all that apply)

- | | |
|--|--|
| ☐ Job / work | ☐ Sleep |
| ☐ Family | ☐ Time |
| ☐ Kids | ☐ Finances |
| ☐ Future ability / independence | ☐ Freedom / lifestyle |
| ☐ Marriage / relationships | ☐ Diminished stress |
| ☐ Self-esteem | ☐ More energy |
| ☐ Appearance / body image | ☐ Improved confidence |
| | ☐ Other: _____ |

Are there health conditions you are afraid this might turn into? (Check all that apply)

- | | |
|---|--|
| ☐ Family health problems | ☐ Depression |
| ☐ Heart disease | ☐ Chronic fatigue |
| ☐ Cancer | ☐ Need surgery |
| ☐ Diabetes | ☐ Other: _____ |
| ☐ Arthritis | ☐ Not sure |
| ☐ Fibromyalgia | ☐ I'm not concerned |

8. EFFECT ON KEY AREAS OF LIFE

How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Please give up to 3 examples:

1. _____

2. _____

3. _____

Date: _____

Weight Loss & Wellness Intake Form

Page 4 of 4

14. RATE YOUR CURRENT HEALTH

Please rate the following on a scale of 1 to 10 (1 being the lowest and 10 being the highest).

Energy Level	1	2	3	4	5	6	7	8	9	10
Quality of Sleep	1	2	3	4	5	6	7	8	9	10
How important is it for you to resolve your health concerns?	1	2	3	4	5	6	7	8	9	10
What is your level of preparedness to make necessary lifestyle changes to achieve your goals?	1	2	3	4	5	6	7	8	9	10

15. AREAS OF INTEREST

I am interested in: (Check all that apply)

☐ Weight Loss
 ☐ Inch Loss
 ☐ Anti-Aging
 ☐ Metabolism Support
 ☐ Red Light Therapy
 ☐ Long-Term Results

16. ADDITIONAL INFORMATION

Is there anything else you would like us to know about your health, weight management journey, or goals that we have not already covered?

17. AGREEMENT

I certify that the information provided on this form is true and complete to the best of my knowledge. I understand that this information will be used to help develop a safe and effective wellness plan tailored to my needs.

Patient Signature: _____ Date: _____

Date: _____

Weight Loss & Wellness Intake Form

Page 3 of 4

9. FUTURE OUTLOOK

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of?
Please be specific.

10. LIFE WITHOUT THIS PROBLEM

What would be different or better without this/these concerns? Please be specific.

11. GOALS & EXPECTATIONS

What do you desire most to get from working with us?

What would that mean to you?

12. SUCCESS AND MOTIVATION

What outcome would you like to see for this to be a success for you?

What potential barriers do you foresee that would prevent the change you are looking for?

13. ADDITIONAL COMMENTS

Is there anything else you would like us to know about your health, weight management journey, or goals that we have not already covered?

Trust Your Gut Wellness Evaluation

In medicine today, leaky gut (intestinal permeability) isn't typically diagnosed. However, that doesn't mean it's not affecting your health. Many health issues related to LGS go undiagnosed, misdiagnosed, or ignored. Please take this quiz to help our doctors evaluate your condition and possible underlying triggers.

Let's get started.

Please check any that apply to you prior to taking the quiz below.

Sub-Clinical symptoms including:

☐ Headaches and migraines

Hormone imbalance including:

☐ PMS

☐ Emotional imbalance

Gastrointestinal issues including:

☐ Abdominal bloating and cramps or painful gas

☐ Irritable Bowel Syndrome

☐ Ulcerative Colitis

☐ Crohn's Disease and other intestinal disorders

Respiratory Conditions including:

☐ Chronic sinusitis

☐ Asthma

☐ Allergies

Autoimmune Conditions including:

☐ Diabetes Mellitus

☐ Lupus

☐ Rheumatoid Arthritis

☐ Fibromyalgia

☐ Chronic Fatigue

Developmental and social concerns including:

☐ Autism

☐ ADD/ADHD

Skin Conditions: (urticaria)

☐ Eczema

☐ Skin rashes

☐ Hives

Please complete our TYG wellness quiz. While there's more to it than a single quiz, the answers below can give you a good idea of how happy your gut really is. Circle the number that most closely fits, then add up your results.

TYG WELLNESS QUESTIONNAIRE

	None	Mild	Mod.	Sev.
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3

	None	Mild	Mod.	Sev.
Asthma, hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Ulcerative colitis or celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight Trouble	0	1	2	3

YOUR TOTAL: _____

0 None 1 Mild 2 Moderate 3 Severe