Account Number: ____________________

WEIGHT LOSS INTAKE

PATIENT DEMOGRAPHICS

Name: ______________________ Birth Date: ____ /____ /____ Sex: ☐ Male ☐ Female

Address: ______________________ City: ____________ State: ________ Zip: ________

E-mail Address: ________________ Phone#: ____________ Social Security#: ____________

Emergency Contact Name/ Number: ________________ /__________ Relationship: ________

Primary Care Physician: ______________________ Doctor's Phone: ______________

How did you hear about our office? ____

HEALTH CONCERNS

Primary Concern: ______________________ Secondary Concern: ______________________

PREVIOUS HISTORY

Have you experienced these same issues in the past? ☐ Yes ☐ No **If yes,** how long have you been dealing with them? ______

Have you tried other treatments in the past? ☐ Yes ☐ No **If yes,** please list all health professionals you have seen: ______

Please list any and all products, procedures, medications, or supplements you have tried prior to now for this condition: ______

QUALITY OF LIFE QUESTIONNAIRE

How has your health condition(s) affected your job? Your finances? Your relationships? Your family? Your hobbies or other activities? Please give examples:

What has that ended up costing you? (Time, Money, Freedom, Sleep, Promotions, Happiness, etc.) Please give examples:

What are you most concerned about regarding your condition?

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

What would instantly be different or better about your life if we could take this problem away immediately?

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

CURRENT MEDICATIONS/SUPPLEMENTS

Please list all medications, drugs, and supplements you currently take, the dosage, and the reason you take them:

☐ Separate List Attached

Medication/Product	Dosage	Reason You Take Them	Date Started

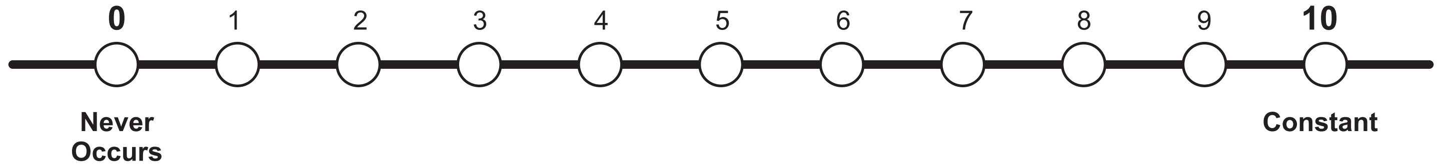
BLUE PRINT TO WEIGHT LOSS

Cash Scale ➤ Compulsions/Cravings ➤ Appetite ➤ Satiety ➤ Hunger

Score each item on a scale of 0-10. Each feeling represents a different part of the brain and different neurotransmitters.

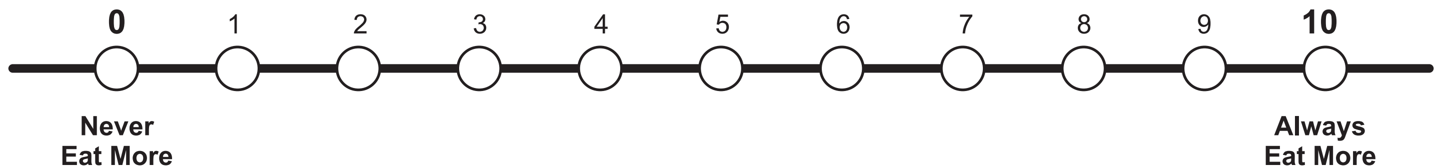
Compulsions/Cravings

Feeling or urge to eat when not hungry. You are full and there is no food in sight yet you get an urge to eat which cannot be repressed.



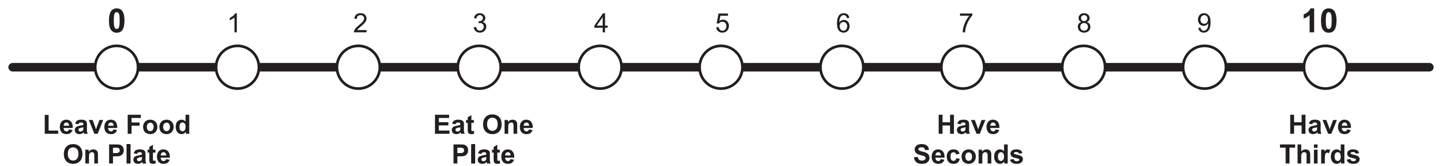
Appetite

Feeling of hunger stimulated by sight, sounds, smells, or social cues. Imagine this scenario: you recently ate and feel full. You walk into a room and there is food everywhere. It looks and smells good and everyone is having fun. You:



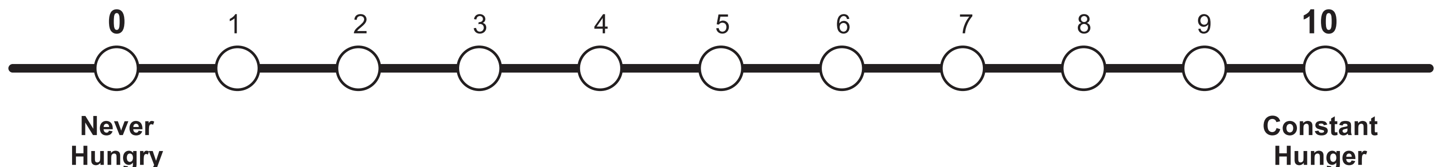
Satiety

A feeling of fullness acquired during eating. When you eat, you usually:

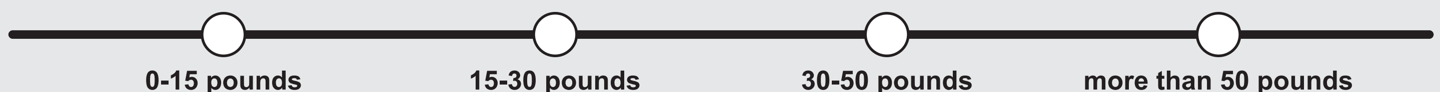


Hunger

That feeling of a pain or ache in your stomach when it is really empty. This is a true pain or discomfort.



How much weight do you want to lose?



COMMENTS:

EATING HABITS

Please be as honest as possible so that we may better help you.

Breakfast

Do you have breakfast every morning? ☐ Always ☐ Sometimes ☐ Never

Approximate time: ____________________

Examples: ____________________

Do you have a snack before lunch? ☐ Always ☐ Sometimes ☐ Never

Approximate time: ____________________

Examples: ____________________

Lunch

Do you have Lunch every Day? ☐ Always ☐ Sometimes ☐ Never

Approximate time: ____________________

Examples: ____________________

Do you have a snack before dinner? ☐ Always ☐ Sometimes ☐ Never

Approximate time: ____________________

Examples: ____________________

Dinner

Do you have Dinner every Day? ☐ Always ☐ Sometimes ☐ Never

Approximate time: ____________________

Examples: ____________________

Do you have a snack at night? ☐ Always ☐ Sometimes ☐ Never

Approximate time: ____________________

Examples: ____________________

OTHER

Do you prefer: ☐ Sweet foods ☐ Salty foods ☐ Fatty foods

Are you a vegetarian? ☐ Yes ☐ No

How many glasses of WATER do you drink in a day? ____________________

How many cups of COFFEE do you drink in a day? ____________________

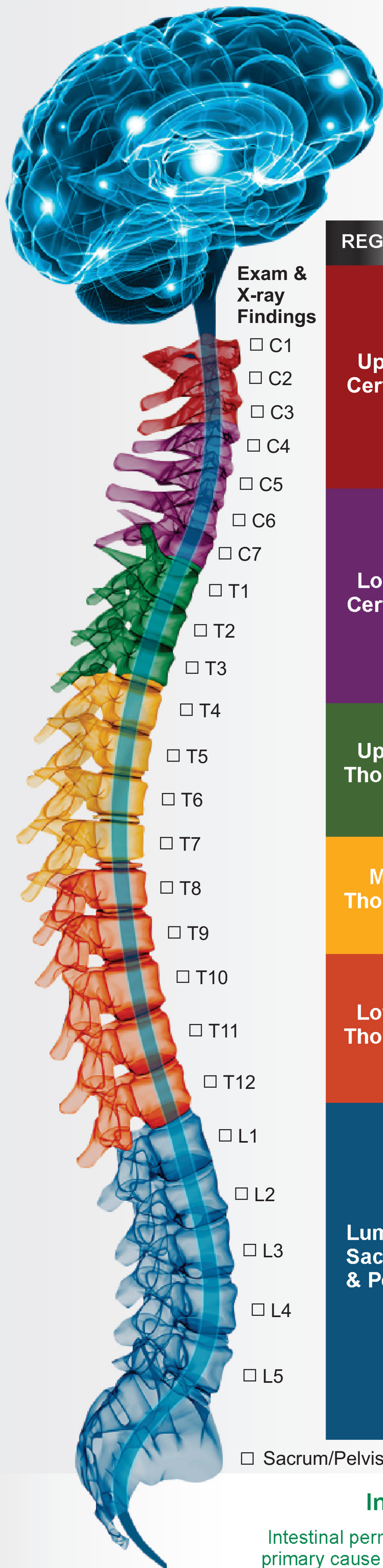
How much soda, sweet tea, or energy drinks do you drink in a day? ____________________

Do you eat a lot of sugar?	☐ 1-2 times per week ☐ 3-4 times per week	☐ Every day ☐ Multiple times per day
Do you eat processed/packaged foods?	☐ 1-2 times per week ☐ 3-4 times per week	☐ Every day ☐ Multiple times per day
Do you eat fast food?	☐ 1-2 times per week ☐ 3-4 times per week	☐ Every day ☐ Multiple times per day

Review of Systems

The nervous system controls and coordinates all organs and structures of the human body.

Please answer the following symptom checklist as thoroughly as possible by marking if you have **ever had** or **currently have** any of the following.



REGIONS	FUNCTIONS	SYMPTOMS ☐ PAST ☐ PRESENT	SYMPTOMS ☐ PAST ☐ PRESENT
Upper Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System	☐☐ Colic & Excessive Crying ☐☐ Ear & Sinus Infections ☐☐ Allergies & Congestion ☐☐ Immune Deficiency ☐☐ Headaches & Migraines ☐☐ Vertigo & Dizziness ☐☐ Sore Throat & Strep	☐☐ Epilepsy & Seizures ☐☐ Sensory & Spectrum ☐☐ ADD / ADHD ☐☐ Focus & Memory Issues ☐☐ Anxiety & Stress ☐☐ Balance & Coordination ☐☐ Speech Issues
Lower Cervical	• Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐☐ Swollen Tonsils & Adenoids ☐☐ Vision & Hearing Issues ☐☐ Low Energy & Fatigue ☐☐ Difficulty Sleeping ☐☐ Pain, Numbness & Tingling in Arms to Hands ☐☐ Poor Circulation/cold Hands	☐☐ TMJ / Jaw Pain ☐☐ Neck and shoulder pain ☐☐ Nausea/vomiting ☐☐ Depression ☐☐ High Blood Pressure ☐☐ Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function • Upper Back Pain	☐☐ Reflux / GERD ☐☐ Chronic Colds & Cough ☐☐ Asthma ☐☐ Mid Back Pain	☐☐ Bronchitis & Pneumonia ☐☐ Heart Conditions ☐☐ Irregular Heart Beat ☐☐ Low Blood Pressure
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐☐ Gallbladder Pain / Issues ☐☐ Jaundice ☐☐ Fever	☐☐ Indigestion & Heartburn ☐☐ Stomach Pains & Ulcers ☐☐ Blood Sugar Problems
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐☐ Behavior Issues ☐☐ Hyperactivity ☐☐ Fatigue ☐☐ Chronic Pain ☐☐ Inflammation	☐☐ Psoriasis and Eczema ☐☐ Skin Conditions / Rash ☐☐ Kidney Problems ☐☐ Gas Pain & Bloating ☐☐ Chronic Stress
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐☐ Constipation ☐☐ Chrohn's, Colitis & IBS ☐☐ Mucus or Blood in Stool ☐☐ Diarrhea ☐☐ Bed-wetting ☐☐ Bladder & Urination Issues ☐☐ Cramps & Menstrual Issues ☐☐ Cysts & Endometriosis ☐☐ Infertility / Impotency ☐☐ Hemorrhoids ☐☐ Hip/ Knee Pain	☐☐ Sciatica & Radiating Pain ☐☐ Lumbopelvic / SI Joint Pain ☐☐ Hamstring Tightness ☐☐ Disc Degeneration ☐☐ Leg Weakness & Cramps ☐☐ Poor Circulation & Cold Feet ☐☐ Pain, Numbness, and Tingling in Legs and Feet ☐☐ Weak Ankles & Arches ☐☐ Lower Back Pain ☐☐ Food Sensitivities

Intestinal Permeability/Leaky Gut Index Score__________

Intestinal permeability (aka leaky gut) is seldom tested for in general medical practice, but it is the primary cause of many chronic health issues we face today. All green shaded items throughout this form are used in the calculation of this score.

SOCIAL HISTORY

Exercise frequency *Type?* ____________________

☐ Daily ☐ 3-4xs/wk ☐ 1-2xs/wk ☐ Rarely ☐ Never

Caffeine Usage ____________________

☐ Daily ☐ Weekly ☐ Occasional ☐ Never

Alcohol Usage ____________________

☐ Daily ☐ Weekly ☐ Occasional ☐ Never

Tobacco Usage *Type and amount?* ____________

☐ Daily ☐ Occasional ☐ Former ☐ Never

Recreational Drug Usage ____________________

☐ Daily ☐ Occasional ☐ Former ☐ Never

NSAID Usage (Tylenol, Aspirin, Ibuprofen, etc.) ____________

☐ Daily ☐ Weekly ☐ Occasional ☐ Never

Antibiotic Usage ____________________

☐ twice or more per year ☐ 1x/year ☐ 1-2 times ever ☐ Never

Comments: ____________________

____

MEDICAL HISTORY

Please mark if you have **EVER HAD** any of the following conditions. Use the comments section to provide details:

Illnesses and Injuries

☐ Cancer
☐ Tumors
☐ Seizures
☐ Diabetes
☐ Autoimmunity
☐ Fibromyalgia
☐ Arthritis/Joint Pain
☐ Osteoporosis
☐ Broken bones
☐ Dislocations
☐ Car Accident
☐ Concussions
☐ Aneurysm
☐ CVA/TIA (stroke)
☐ Heart Attack
☐ Blood Clots
☐ Heart Disease
☐ Other__________

Hospitalizations and Surgeries

Procedure	Date Performed
☐ Orthopedic	____/____/_______
☐ Spinal	____/____/_______
☐ Cancer	____/____/_______
☐ Other__________	____/____/_______
☐ Other__________	____/____/_______

Are you currently pregnant or breastfeeding? ☐ Yes ☐ No ____________________

Comments: ____________________

____

FAMILY HISTORY

Has anyone in your immediate family (Parents, Grandparents, Siblings, or Children) suffered from any of the following?

☐ Heart Disease ☐ Hypertension ☐ Stroke ☐ Aneurysm ☐ Cancer ☐ Diabetes ☐ Other

☐ Unknown or Unremarkable (No history of disease or illness)

If yes, please explain: ____________________

____

____

ALLERGIES

Do you have any allergies to medications, supplements, foods, or other? ☐ **No known allergies** ☐ **Yes**

If Yes, please provide details on what the allergy is to, symptoms you experienced, what you currently do for treatment, and if it is well controlled or not. ____________________

____

____

I have answered the above questions on this form to the best of my ability, and certify them to be true and accurate to the best of my knowledge. I hereby authorize payment to be made directly to Motus Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability, and that I will remain financially responsible to Motus Chiropractic for any and all services I receive at this office.

____
Patient or Authorized Person's Signature

_______/_______/____________
Date Completed

____
Doctor's Signature

_______/_______/____________
Date Completed