

Rapid Weight Loss Intake Form

Name _____ Date of Birth _____ Phone _____
 email: _____ Address _____

1. Primary reasons for weight loss: _____
2. What is your current weight and your desired weight? _____
3. Please list **all** of your current diagnoses (medical conditions): _____

4. Please list *any* current or past major illnesses or other hospitalizations: _____

5. Please list **ALL** Medications and supplements: _____

6. Emergency contact (name, number, relation) _____
7. How motivated are you to improve your health (0-10)? _____
8. How willing are you to make lifestyle changes (0-10)? _____
9. Do you have any of these conditions? (Please circle all that apply):

<ul style="list-style-type: none"> • Weak or compromised immune system • Hard to control Diabetes • Graves Disease • Pregnant or Breastfeeding • Gout • Unstable angina • Cancer not in remission for over 5 years • High blood pressure requiring more than 1 Prescription drug to treat 	<ul style="list-style-type: none"> • Hypothyroidism • Diabetes • Hypertension • Alcoholism or addiction (past or present) • Anxiety • Depression • Electrolyte imbalances • Cardiac arrhythmia (past or current)
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10. Anything else a health care provider should know about: _____

I hereby consent to treatment. I have listed all my known medical conditions and physical limitations and will inform the acupuncture physician in writing of any change in my physical health or insurance plan between sessions. I understand that my acupuncturist must be aware of any and all existing physical conditions that I have in order to provide an appropriate treatment. I also understand that the acupuncturist will not diagnosis illness, disease, or any other medical, physical, or emotional disorder. I am responsible for consulting a qualified medical doctor for any ailment that may I have.

I herby commit to follow the program to the best of my ability and acknowledge that there is no guarantee regarding the weight loss program results. **I am aware of the possible side-effect of this program, which includes, but is not limited to: withdrawal, weakness, dehydration, electrolyte imbalance, reduced immune response, lower blood pressure, energy loss, and constipation.**

I agree to pay for missed services if I do not give 24 hour notice of cancellation.
Package is non-refundable and non-transferable. Supplement refills are \$150. After 6 months, full price applies.

 Signature Name Date

	WEIGHT	BMI	%BF L	MM	H2O	BONE	HT	%BF U	BMI	BP	HR
BEFORE											
AFTER											

	WAIST			
BEFORE				
AFTER				

