PEAK
WEIGHT LOSS

Full name: ____ Today's date: ________________________

Preferred name: ________________________________ Marital status: single / married / divorced / widowed / other

Address: ____ City: ________________________ State: ______ Zip: _______________

Contact number: ________________________ E-mail address ____

Gender: Male Female Birth date: ___________________ Social Security #: ____

Occupation: ______________________________________ Employer name: ____

Emergency contact name: ____________________ Phone: _______________ Relationship __________________________________

Primary physician: ___________________________ Office: _________________________ Date of last visit: ___________________

How did you hear about us? ____

Would you like appointment reminders? (circle one) Yes No If yes, email or text? _________________________

What is your current weight? _____________________ Height? ______________________

What is your current activity level? (circle one) LOW MODERATE HIGH

What is your "Goal Weight"? _______________________ When was the last time you weighed that? ____________________

Has your doctor recommended you to lose weight? (circle one) YES NO

Have you tried to lose weight in the past? (circle one) YES NO

If "YES", please describe:

____

____

What are your top 2 reasons why you want to lose weight, improve your health and live well?

1. ____ 2. ____

On a scale of 1-10, with 10 meaning "I'M SERIOUS ABOUT LOSING WEIGHT AND FULLY COMMITTED" what is your current level of commitment? (circle one) 1 2 3 4 5 6 7 8 9 10

Please check ✓ all symptoms you have ever had (S=self), even if they do not seem related to your current problem, and mark (F=family) if you have a family history of any of them.

S	F		S	F		S	F		S	F	
☐	○	Stroke	☐	○	Epilepsy	☐	○	Headaches	☐	○	Depression
☐	○	Heart Attack	☐	○	Hypoglycemia	☐	○	Neck Pain/Stiffness	☐	○	Mood Swings
☐	○	Diabetes	☐	○	Pacemaker	☐	○	Back Pain/Stiffness	☐	○	Stress
☐	○	Thyroid Disease	☐	○	Organ Transplant	☐	○	Loss of Balance	☐	○	Poor Sleep
☐	○	Gallbladder Disease	☐	○	Intestine problems	☐	○	Dizziness	☐	○	Fatigue
☐	○	Kidney Disease	☐	○	Constipation	☐	○	Arthritis	☐	○	Hot Flashes
☐	○	Liver Disease	☐	○	Stomach	☐	○	Skin Conditions	☐	○	Cold Feet
☐	○	High Blood Pressure	☐	○	Heartburn	☐	○	Hair Loss/Thinning	☐	○	Hysterectomy
☐	○	High Cholesterol	☐	○	Gout	☐	○	Bipolar Disorder	☐	○	Anxiety
☐	○	Shortness of Breath	☐	○	Cancer (Type: ____)						

****Please turn over to complete the back side****

List any medications you are taking & what for:

____

____

List any major hospitalizations, operations or illness:

____

____

Have you been treated by a physician in the last 12 months? (circle one) **YES NO**
If "YES", please describe:

____

Are you under regular chiropractic care? (circle one) **YES NO**
In addition to weight loss, if there was one other health condition or struggle that you would love to see your body heal and/or overcome, what would that be?

____

PLEASE CIRCLE YES OR NO TO THE QUESTIONS BELOW:
YES NO Are you currently taking either, Steroids, Estrogen or undergoing any Hormone Replacement Therapy? If yes, please explain

____

YES NO Are you currently taking any blood thinners? If yes, please explain

____

YES NO Do you have heart problems? If yes, please explain

____

YES NO Do you take insulin for diabetes? If yes, please explain

____

YES NO Do you suffer from mental illness including anxiety/depression? If yes, please explain

____

YES NO Are you or have you been suffering from an eating disorder? If yes, please explain

____

YES NO Have you had a serious health complication attempting a detox, weight loss or lifestyle program in the last five years? If yes, please explain

____

YES NO Do you have current or a history of bladder dysfunction? (i.e. leakage, frequent urination, waking up during the night, etc.) If yes, please explain

____

Females only (circle yes or no)
YES NO Are you pregnant?
YES NO Are you breast feeding?
YES NO Are you on birth control

PRIMARY CARE MEDICAL WAIVER
*I understand that the information I provided on this document is relative to my capacity of completing any lifestyle program designed and implemented by your establishment and answering **YES** to any of the questions above shall require further discussion with my primary care physician and clearance prior to initiating such program.*
I further acknowledge and agree that, I waive any claims I may have against your establishment, or any of your employees, or agents and agree to hold you harmless and indemnify your establishment, your employees, or agents from and against any and all claims, damages, causes of action or injuries relating to any of the lifestyle programs I enroll in because I understand it is my responsibility to:
1. Complete this form with accuracy and to disclose any related information to the questions I completed with integrity.
2. Consult with my primary care physician on any medications, supplements, product interactions, historical and present medical conditions, diagnoses and treatment, prior to, during, and after completing any lifestyle program.
3. I will provide any documentation from my primary care physician to your establishment should it be in relation to the lifestyle program, directly or indirectly.

CLIENT SIGNATURE ____ **DATE** _________________________

PRINT CLIENT NAME ____