GET SLIM Rochester

New Client Health Questionnaire

NAME:_____ TODAY'S DATE:_____

MARITAL STATUS: SINGLE / MARRIED / DIVORCED / WIDOWED / OTHER

ADDRESS:_____CITY:_____STATE:____ZIP:_____

PHONE NUMBER: HOME_____ CELL _____

EMAIL ADDRESS: _____ GENDER: MALE / FEMALE

DATE OF BIRTH: _____ HEIGHT:_____

OCCUPATION: _____

YOUR ACTIVITY LEVEL: LOW / MODERATE / HIGH / INTENSE

WOULD YOU LIKE APPOINTMENT REMINDERS? YES / NO

YOUR HEALTH SUMMARY

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	☐	○	MOOD SWINGS
☐	○	HEART ATTACK	☐	○	HYPOGLYCEMIA	☐	○	NECK PAIN	☐	○	LOSS OF BALANCE
☐	○	DIABETES	☐	○	PACEMAKER	☐	○	POOR SLEEP	☐	○	NERVOUSNESS
☐	○	THYROID DISEASE	☐	○	ORGAN TRANSPLANT	☐	○	DIZZINESS	☐	○	STOMACH
☐	○	GALLBLADDER DISEASE	☐	○	HIGH BLOOD PRESSURE	☐	○	HYSTERECTOMY	☐	○	HAIR LOSS/ THINNING
☐	○	KIDNEY DISEASE	☐	○	INTESTINE PROBLEMS	☐	○	MID BACK PAIN	☐	○	COLD FEET
☐	○	DEPRESSION	☐	○	SHORTNESS OF BREATH	☐	○	LOWER BACK	☐	○	HOT FLASHES
☐	○	GOUT	☐	○	HIGH CHOLESTEROL	☐	○	PAIN	☐	○	HEARTBURN

List any medications you are taking & what for: _____

_____

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?_____

Are you under regular chiropractic care? **YES / NO**

How long have you been overweight?_____ Have you tried to lose weight in the past? **YES / NO**

Has your doctor recommended you to lose weight? **YES / NO**

What is your "GOAL WEIGHT"? _____ When is the last time you weighed that? _____

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

Are you currently taking either, Insulin, Steriods, Estrogen or undergoing any Hormone Replacement therapy? **YES / NO**

FEMALES:

Are you pregnant? **YES / NO**

Are you breast feeding? **YES / NO**

Are you on birth control? **YES / NO**

Do you have estrogen patch or implant? **YES / NO**

(PLEASE TURN OVER AND COMPLETE OTHER SIDE)

215 Spencerport Road Rochester, NY 14606 Phone: (585)623-1397

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EATING HABITS

PLEASE BE AS HONEST AS POSSIBLE SO THAT WE MAY BETTER HELP YOU.

BREAKFAST

DO YOU HAVE BREAKFAST EVERY MORNING? YES / SOMETIMES / NO

APPROXIMATE TIME: _____:_____

EXAMPLES:_____

LUNCH

DO YOU HAVE LUNCH EVERY AFTERNOON? YES / SOMETIMES / NO

APPROXIMATE TIME: _____:_____

EXAMPLES:_____

DINNER

DO YOU HAVE DINNER EVERY EVENING? YES / SOMETIMES / NO

APPROXIMATE TIME: _____:_____

EXAMPLES:_____

SNACK

DO YOU HAVE A SNACK EVERYDAY? YES / SOMETIMES / NO

APPROXIMATE TIME: _____:_____

EXAMPLES:_____

HOW DID YOU HEAR ABOUT US?

- ☐ FRIEND / FAMILY
- ☐ BILLBOARD
- ☐ BROCHURE
- ☐ CURRENT CHIROPRACTIC MEMBER
- ☐ FACEBOOK
- ☐ INTERNET: BING SEARCH
- ☐ INTERNET: GOOGLE
- ☐ INTERNET: YAHOO
- ☐ TELEVISION
- ☐ RADIO: WHAT STATION?_____