# Weight Loss

blueprint to Weight Loss

## PERSONAL INFORMATION

**Name** _____ **Date** _____

**Address** _____

**City** _____ **State** _____ **Zip** _____

**Phone** *(Home)* _____ *Mobile* _____

**Email** _____ **Date of Birth** _____

**Age** _____ **Height** _____ **Occupation** _____

***Who may we thank for referring you to our office?***

**Friend or Family** _____ **Health Care Provider** _____

**Online Search** _____ **Wellness Class** _____ **Other** _____

## MEDICAL HISTORY

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

| | | |
|---|---|---|
| ☐ Depression | ☐ Brain fog | ☐ Headache |
| ☐ Heart Attack | ☐ Hypoglycemia | ☐ Neuropathy/nerve problems |
| ☐ Diabetes | ☐ Anemia | ☐ Poor Sleep |
| ☐ Thyroid Disease | ☐ Cancer | ☐ Dizziness |
| ☐ Gallbladder Disease | ☐ High Blood Pressure | ☐ Arthritis |
| ☐ Kidney Disease | ☐ Intestine Problems | ☐ Weight gain |
| ☐ Stroke | ☐ Shortness of Breath | ☐ Back Pain |
| ☐ Fatigue | ☐ High Cholesterol | ☐ Carpal Tunnel |

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

_____

Are you taking any medications/supplements? _____ If Yes, please list _____

_____

Are you pregnant? _____ How many children? _____ How many pregnancies? _____

Are you breast feeding? _____

Any known allergies? _____ If Yes, please list _____

_____

Main Concerns:

1. _____ 2. _____

3. _____ 4. _____

How long have you had this/these concerns? _____

blueprint to Weight Loss

What effect does this have on your body functions or quality of life? _____

_____

**What would be different or better without this/these concerns?**

☐ Diminished Stress ☐ More Energy ☐ Improved Self-Esteem ☐ Confidence ☐ Sleep

☐ Work ☐ Family ☐ Outlook

**How have you addressed weight management in the past?**

☐ Medications ☐ Vitamins ☐ Exercise ☐ Diet and Nutrition ☐ Other _____

**How did the previous methods work for you?** _____

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

_____

_____

**Do you feel it possible to eliminate or prevent these potential barriers?** _____

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

_____

_____

**Please rate on a scale of 1-10 (1 being the lowest and 10 being the highest)**

Energy Level

Quality of Sleep

How Important It Is For You To Resolve Your Health Concerns

What Is Your Level of Preparedness To Make Necessary Lifestyle Changes To Achieve Your Goals?

## I am interested in:

***Weight loss*** ☐ ***Inch Loss*** ☐ ***Anti-Aging*** ☐ ***Metabolism Support*** ☐

***Long Term Results*** ☐

Thank you

blueprint nutrition

# Trust Your Gut Wellness Evaluation

In medicine today, leaky gut aka 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 are ignored by traditional medicine. Please take the quiz to help our doctors evaluate how we can help your condition and any underlying triggering limiting your health in process

## *Let's get started.*

Please circle 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:

- ☐ Austism
- ☐ 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 | Moderate | Severe |
|---|---|---|---|---|
| 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 | Moderate | Severe |
|---|---|---|---|---|
| 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:** _____

CONTOUR LIGHT

# Treatment Consent Form

| Patient | Provider |
| --- | --- |
| | AMAZING WELLNESS & CHIROPRACTIC |

This consent to treatment form explains the risks and benefits of the Contour Light treatments. Patient understands the following:

1. Results vary greatly from person to person. No result is guaranteed.
2. Contour Light is a treatment intended to be implemented in conjunction with a modification in diet and lifestyle as part of a complete protocol. The recommended diet and lifestyle is a critical part of the program and are essential in achieving the maximum results.
3. Temporary hyper pigmentation/hypo pigmentation (changes in skin color) on rare occasion may occur as a result of treatment.
4. Contour Light should not be used by patients with any of the conditions listed below.

**Conditions that Prevent Treatment**

Patient agrees (by initialing) that all of the following are true:

_____ I am over the age of 18

_____ I do not have and never had any of the following medical conditions:

- Cancer (active or within 1 Year of remission)
- HIV/AIDS
- Hepatitis C or D
- Uncontrolled High Blood Pressure

_____ I am not pregnant or breastfeeding

_____ I do not have a pacemaker

**SIGNATURE**

By signing below, patient agrees that provider listed above may perform the Contour Light procedure for the purpose of body contouring. Patient understands and accepts the risks listed above and agrees that all information provided on this form is true and correct to the best of patient's knowledge.

Patient Signature _____ Date _____

**DISCLOSURE TO THIRD PARTIES (OPTIONAL)**

By signing below, patient agrees to permit provider and third parties authorized by provider to use patient's name, photos and/or videos in the marketing of the Contour Light system and procedure. Absent a signature, provider will not disclose patient's identity to any third party except as required by law.

Patient Signature _____ Date _____

Date:

AMAZING WELLNESS & CHIROPRACTIC

HR #:

I hereby authorize payment to be made directly to Amazing Wellness and 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 Amazing Wellness and Chiropractic for any and all services I receive at this office.

_____ _____-_____-_____

Patient or Authorized Person's Signature Date Completed

**Financial Policy**

Please take a few moments to review the following information prior to your appointment.

We hope you understand that our financial policies are established to assure the financial resources needed to maintain this chiropractic office for all our patients and the services that they need and want. We will work to ensure that your chiropractic care does not become a financial burden.

Charges for services are due and payable between you and your health insurance status. We accept cash, personal checks, and credit cards for payment on your account.

**About Health Insurance**

Your insurance policy is an agreement between you and your insurance company. Our relationship is with you, not your insurance company. Therefore, all charges are ultimately your responsibility, regardless of your insurance status.

**Missed Appointment Policy**

At Amazing Wellness and Chiropractic, we understand that life happens, however, due to necessity and appointment availability, we must respect all of our patient's time, as well as yours. Therefore, any appointment rescheduling must be done at least 24 hours prior to the scheduled appointment time.

If the patient fails to call and reschedule within the 24 hours of the scheduled appointment time and "no call no shows", a $20 missed appointment fee will be charged to the patient's account. The $20 missed appointment fee must be paid prior to any services being rendered.

I have read and understand the above policies.

_____ _____-_____-_____

Patient or Authorized Person's Signature Date Completed

_____ _____-_____-_____

Doctor's Signature Date Form Reviewed