Dr. Scott B. Smith, DC

the Slim Co

Patient Information:

Date: _____________

Patient Name: ____

Last First MI

Sex: M F Birthdate_____/_____/_____ Age: __________ Height : __________ Weight: __________

Please answer the following questions honestly so we can do our best to help you reach your goals

Who encouraged you to lose weight? ____

On a scale of 1-10 – How important is it to you to lose weight? ____

What important reason, special occasion, or goal date do you have to lose weight? ______________________________

How many pounds would you like to lose? ________________________ How fast do you want lose the weight? _________________________

Have you ever attended any other weight reduction centers, if so, which ones? _________________________________

What kinds of diets have you tried on your own? ____

What is the longest you have been able to stick with a diet? ____

Would you commit to one visit a week? ☐ Yes ☐ No

Does your family support your weight loss efforts? ☐ Yes ☐ No

Have you been advised by your family physician to lose weight? ☐ Yes ☐ No

If you answered yes, what is your doctor's name? ____

Do you eat because of emotions? ☐ Yes ☐ No

If you answered yes, please explain: ____

Have you ever been hospitalized, under medical care, or checked into rehab for alcohol or drug treatment? ☐ Yes ☐ No

If you answered yes, please explain: ____

____

Females Only: **Date of Last Menstrual Period: __________________________**

On average, which of the following reflects your daily eating habits? (Please check all that apply):

☐ 3 meals with healthy snacks ☐ 3 meals ☐ 2 meals or less ☐ Skip breakfast or other meals

☐ Generally eat on the run ☐ No regular eating pattern ☐ Often crave sweets/carbs

☐ Graze; small, frequent meals (How many per day? ______)

On average what is your exercise/activity level?

☐ None

☐ Light (1-3 times/week, easy pace)

☐ Moderate (2-3 times/week, moderate pace some weights)

☐ Heavy (3-4 times/week, vigorous pace, weights, fast running)

Body Profile

Which area(s) of your body (if any) are you interested in treating for fat loss/reduction?

☐ Chin ☐ Arms ☐ Abdomen ☐ Love Handles ☐ Back ☐ Thighs ☐ Hips ☐ Buttocks

Which area(s) of our body (if any) are you interested in treating for the improvement of cellulite?

☐ Chin ☐ Arms ☐ Abdomen ☐ Love Handles ☐ Back ☐ Thighs ☐ Hips ☐ Buttocks

Food and Chemical Sensitivity

Office Use Only:
Total Points: ___________________________

Please complete the following survey using the key below

☑ ☐ ☐ ☐ = No symptoms (0 points)
☐ ☑ ☐ ☐ = Mild symptoms (1 point)
☐ ☐ ☑ ☐ = Moderate symptoms (2 points)
☐ ☐ ☐ ☑ = Severe symptoms (3 points)

Weight:
- ☐ ☐ ☐ ☐ Inability to lose weight
- ☐ ☐ ☐ ☐ Food cravings
- ☐ ☐ ☐ ☐ Binge eating
- ☐ ☐ ☐ ☐ Nausea or vomiting
- ☐ ☐ ☐ ☐ Water retention

Digestive Symptoms:
- ☐ ☐ ☐ ☐ Stomach pains or cramping
- ☐ ☐ ☐ ☐ Constipation
- ☐ ☐ ☐ ☐ Diarrhea
- ☐ ☐ ☐ ☐ Reflux or heartburn
- ☐ ☐ ☐ ☐ Bloating
- ☐ ☐ ☐ ☐ Gas

Head and Ears:
- ☐ ☐ ☐ ☐ Migraines
- ☐ ☐ ☐ ☐ Headaches
- ☐ ☐ ☐ ☐ Earaches
- ☐ ☐ ☐ ☐ Wheezing
- ☐ ☐ ☐ ☐ Ear infection
- ☐ ☐ ☐ ☐ Ringing in ears

Eyes and Throat:
- ☐ ☐ ☐ ☐ Itchy eyes
- ☐ ☐ ☐ ☐ Watery eyes
- ☐ ☐ ☐ ☐ Sore throat
- ☐ ☐ ☐ ☐ Persistent canker sores

Sinus and Respiratory:
- ☐ ☐ ☐ ☐ Stuffy or runny nose
- ☐ ☐ ☐ ☐ Asthma
- ☐ ☐ ☐ ☐ Chest congestion
- ☐ ☐ ☐ ☐ Chronic cough
- ☐ ☐ ☐ ☐ Frequent sneezing

Skin Disorders:
- ☐ ☐ ☐ ☐ Dermatitis
- ☐ ☐ ☐ ☐ Excessive sweating
- ☐ ☐ ☐ ☐ Rashes
- ☐ ☐ ☐ ☐ Hives
- ☐ ☐ ☐ ☐ Eczema

Emotional and Mental
- ☐ ☐ ☐ ☐ Depression
- ☐ ☐ ☐ ☐ Anxiety
- ☐ ☐ ☐ ☐ Mood swings
- ☐ ☐ ☐ ☐ Irritability
- ☐ ☐ ☐ ☐ Poor concentration

Energy:
- ☐ ☐ ☐ ☐ Fatigue
- ☐ ☐ ☐ ☐ Lethargy
- ☐ ☐ ☐ ☐ Restlessness
- ☐ ☐ ☐ ☐ Insomnia
- ☐ ☐ ☐ ☐ Hyperactivity

Other Symptoms:
- ☐ ☐ ☐ ☐ Joint pain
- ☐ ☐ ☐ ☐ Arthritis
- ☐ ☐ ☐ ☐ Irregular heartbeat
- ☐ ☐ ☐ ☐ Muscle aches

Please List Unmentioned Symptoms:

____
____
____
____
____

What is most important to you in deciding to use our services? (Please check all that apply):

- ☐ Effectiveness "My results are my top priority."
- ☐ Service "I need extra support along the way."
- ☐ Time "I want results quickly."
- ☐ Ease "I have a difficult time losing weight."

I understand that my patient file will be kept completely confidential unless I give written permission for my information to be released.

_______________________________________ **Signature:**

__________________________ **Date:**