Discover Medical Center

Weight Loss Red Light Intake Form

PERSONAL INFORMATION

Name: _____ **Date:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____ **Email:** _____

Date of Birth: _____ **Age:** _____ **Height:** _____

Occupation: _____

Who may we thank for referring you to our office?

Friend/Family: _____ **Health Care Provider:** _____

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

MEDICAL HISTORY

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

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

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

_____

_____

03 **Are you taking any medications/supplements? If yes, please list.**

_____

_____

04 **Are you pregnant? _____** **How many children?_____**
Are you breast feeding? _____ **How many Pregnancies? _____**

05 **Any known allergies? If yes, please list.**

_____

_____

06 Main Concerns:

1. _____ **3.** _____

2. _____ **4.** _____

07 How long have you had this/these concerns?

_____

_____

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

_____

_____

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

- ☐ Diminished Stress
- ☐ Work
- ☐ More Energy
- ☐ Family
- ☐ Improved Self-Esteem
- ☐ Outlook
- ☐ Confidence
- ☐ Sleep

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

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

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

_____

_____

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

_____

_____

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

_____

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

_____

_____

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

Energy Level	1	2	3	4	5	6	7	8	9	10
Quality of Sleep	1	2	3	4	5	6	7	8	9	10
How Important It Is For You To Resolve Your Health Concerns	1	2	3	4	5	6	7	8	9	10
What Is Your Level of Preparedness To Make Necessary Lifestyle Changes To Achieve Your Goals?	1	2	3	4	5	6	7	8	9	10

I AM INTERESTED IN:

☐ Weight Loss ☐ Anti-Aging ☐ Long-Term Results

☐ Inch Loss ☐ Metabolism Support