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

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

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

_____

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

_____

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

Are you breast feeding? NA

Any known allergies? NA 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	Select
Quality of Sleep	Select
How Important It Is For You To Resolve Your Health Concerns	Select
What Is Your Level of Preparedness To Make Necessary Lifestyle Changes To Achieve Your Goals?	Select

I am interested in:

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

Long Term Results ☐

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 _____

blueprint to Gut Health

PRACTICE INFORMATION HERE

Patient Quality Of Life Survey

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

Please take several minutes to answer these questions so we can help you get better.
(Please circle as many that apply)

1 How have you taken care of your health in the past?

- ☐ Medications
- ☐ Emergency Room
- ☐ Routine Medical
- ☐ Exercise
- ☐ Nutrition/Diet
- ☐ Holistic Care
- ☐ Vitamins
- ☐ Chiropractic
- ☐ Other (please specify): _____

2 How did the previous method(s) work out for you?

- ☐ Bad results
- ☐ Some results
- ☐ Great results
- ☐ Nothing changed
- ☐ Did not get worse
- ☐ Did not work very long
- ☐ Still trying
- ☐ Confused

3 How have others been affected by your health condition?

- ☐ No one is affected
- ☐ Haven't noticed any problem
- ☐ They tell me to do something
- ☐ People avoid me

4 What are you afraid this might be (or beginning) to affect (or will affect)?

- ☐ Job
- ☐ Kids
- ☐ Future ability
- ☐ Marriage
- ☐ Self-esteem
- ☐ Sleep
- ☐ Time
- ☐ Finances
- ☐ Freedom

5 Are there health conditions you are afraid this might turn into?

- ☐ Family health problems
- ☐ Heart disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Depression
- ☐ Chronic Fatigue
- ☐ Need surgery

How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:

What are you most concerned with regarding your problem?

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific

What would be different/better without this problem? Please be specific

What do you desire most to get from working with us?

What would that mean to you?

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: _____

AMAZING WELLNESS & CHIROPRACTIC

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 with 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 24 hours of the scheduled appointment time and “no call no shows”, the full fee of the appointment will be forfeited. If the patient fails to call and reschedule a second appointment and "no call no shows", a $20 missed appointment fee will be charged to the patient’s account and the $20 must be paid prior to receiving the services on the rescheduled day.

I have read and understand the above policies.

Signature: _____ Date: _____