NewLife
Wellness & Weight Loss

NEW CLIENT QUESTIONNAIRE

FULL NAME: _____ TODAY'S DATE: _____

PREFERRED NAME: _____ MARITAL STATUS: SINGLE / MARRIED / DIVORCED / WIDOWED / OTHER

ADDRESS: _____ CITY: _____ STATE:_____ ZIP : _____

HOME ☐ _____ WORK ☐ _____ CELL ☐ _____

EMAIL ADDRESS: _____ GENDER: ☐ MALE ☐ FEMALE

BIRTH DATE: _____ HEIGHT: _____

OCCUPATION: _____ EMPLOYER NAME: _____

SPOUSE: _____ YOUR ACTIVITY LEVEL: ☐ LOW ☐ MODERATE ☐ HIGH ☐ INTENSE

YOUR HEALTH SUMMARY

Please ☑ check all symptoms you have ever had (s=self), even if they do not seem related to your current problem, & mark (f=family) if you have a family history of any of them, like this ☑

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 PAIN	☐	◯	HOT FLASHES
☐	◯	GOUT	☐	◯	HIGH CHOLESTEROL	☐	◯	CANCER (TYPE: _____)	☐	◯	HEARTBURN

List any medications and or supplements 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? _____

If "YES", please describe: _____

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**

What are your top 2 reasons why you want to lose weight, improve your health and thrive? 1. _____ 2. _____

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 COMMITTED" what is your current level of commitment? **1 2 3 4 5 6 7 8 9 10**

Are you currently taking either, Insulin, Steroids, 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 an estrogen patch or implant? ☐ **YES** ☐ **NO**

(PLEASE TURN OVER AND COMPLETE OTHER SIDE.)

HOW DID YOU FIND OUT ABOUT US?

PLEASE CHECK ALL THAT APPLY

- ☐ FRIEND/FAMILY _____
- ☐ MALL SIGN
- ☐ BROCHURE
- ☐ CURRENTLY A CHIROPRACTIC MEMBER
- ☐ NEWSPAPER _____
- ☐ NEWSPAPER _____
- ☐ NEWSPAPER _____
- ☐ FACEBOOK
- ☐ INTERNET: BING SEARCH
- ☐ INTERNET: GOOGLE
- ☐ INTERNET: YAHOO
- ☐ COUPON BOOK
- ☐ LOCATION