WINCHELL
CHIROPRACTIC & WELLNESS CENTER

Weight Loss Profile

Name____ Date_________________________

Address_____________________________ City____________________ State_______ Zip___________

Preferred Phone______________________________ Email_______________________________________

Age________ Birth Date___________________ Sex ☐ M ☐ F Marital Status ☐ S ☐ M ☐ D ☐ W

Employer____ Occupation______________________________

How did you hear about us? _____________________ Who may we thank for referring us?__________________

Weight____________________ Goal Weight___________________ Desired Completion Date________________

Minimum Adult Weight___________________ at age____________

Maximum Adult Weight__________________ at age_____________

Do you exercise? ☐ Yes ☐ No If yes, please describe:___________________________ How often?_________

Have you been on a diet before? ☐ Yes ☐ No

If yes, please specify which diet and why you think it didn't work for you:___________________________________

____

Current Medical Concerns

Are you currently being treated for any medical concerns? ☐ Yes ☐ No

Please list any physicians you currently see, along with their specialty and reasons you are seeking care:___________

____

____

____

Are you currently taking any medication? ☐ Yes ☐ No

Please list all medications, supplements, herbs, vitamins:____

____

____

General Medical History

Do you have cancer? ☐ Yes ☐ No Are you in cancer remission? ☐ Yes ☐ No If yes, how long?__________

Are you pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If yes, how much per day?________________ How many years?______________

Allergies

Do you have FOOD allergies? ☐ Yes ☐ No If yes, please list:____

Do you have MEDICATION allergies? ? ☐ Yes ☐ No If yes, please list:____________________________________

Diabetes/Sugar Handling

Do you tend to be hypoglycemic? ☐ Yes ☐ No

Do you have diabetes? ☐ Yes ☐ No (If no, skip to Cardiovascular Function)

Are you under the care of a physician for diabetes? ☐ Yes ☐ No

Which type of diabetes do you have?

- ☐ Type I – Insulin dependent (insulin injections only)
- ☐ Type II – Non-insulin dependent (diabetic medication)
- ☐ Type II – Insulin dependent (diabetic mediation and insulin injections)

Is your blood sugar level monitored? ☐ Yes ☐ No

If yes, by whom? ☐ Myself ☐ Physician ☐ Other (please specify):____

Are you taking medication for this condition? ☐ Yes ☐ No If yes, please specify:_______________________________

Cardiovascular Function

Do you have high blood pressure? ☐ Yes ☐ No

Do you have your blood pressure checked regularly? ☐ Yes ☐ No

Have you had a cardiovascular event? ☐ Yes ☐ No If yes, please specify date(s):____________________________

If yes, please explain event(s)____

Are you under the care of a physician for a cardiovascular condition? ☐ Yes ☐ No

Are you taking medication for a cardiovascular condition? ☐ Yes ☐ No

If yes, please list:____

Do you have a history of arrhythmia? ☐ Yes ☐ No

Have you been diagnosed with Congestive Heart Failure (CHF)? ☐ Yes ☐ No

Kidney Function

Have you been diagnosed with kidney disease? ☐ Yes ☐ No

Have you had kidney stones? ☐ Yes ☐ No

Have you had gout? ☐ Yes ☐ No

Are you under the care of a physician for a kidney condition? ☐ Yes ☐ No

Are you taking any medications for a kidney condition? ☐ Yes ☐ No

If yes, please list:____

Colon Function

Do you have any of the following? (select all that apply)

☐ Irritable Bowel ☐ Colitis ☐ Diarrhea ☐ Diverticulosis ☐ Crohn's Disease ☐ Constipation

☐ Other:_______________________________ ☐ None (if none, skip to Stomach/Digestive)

Are you under the care of a physician for any colon-related condition? ☐ Yes ☐ No

Are you taking any medication for a colon-related condition? ☐ Yes ☐ No If yes, please specify:_______________

Other than medication, how are you currently treating this condition? ____

____

Stomach/Digestive Function

Do you have any of the following? (select all that apply)

☐ Acid Reflux ☐ Gastric Ulcer ☐ Heartburn ☐ Celiac Disease ☐ Crohn's Disease

☐ Other:_____________________________ ☐ None (if none, skip to next section)

Are you under the care of a physician for stomach/digestive function? ☐ Yes ☐ No

Are you taking any medication for stomach/digestive function? ☐ Yes ☐ No If yes, please list:_______________

____

Ovarian/Breast Function (women only)

Do you have any of the following? (select all that apply)

☐ Irregular Periods ☐ Menopause ☐ Painful Periods ☐ Heavy Periods ☐ Amenorrhea

☐ Hysterectomy ☐ Heavy Periods ☐ Uterine Fibroma ☐ Cancer ☐ None (if none, skip to next section)

Are you under the care of a physician for ovarian/breast issues? ☐ Yes ☐ No

Are you taking any medication for ovarian/breast issues? ☐ Yes ☐ No If yes, please list:_____________________

____

Dietary Habits

Are you a vegetarian? ☐ Yes ☐ No

How many glasses of WATER do you drink per day?___________________

How many cups of COFFEE do you drink each day?___________________

Do you drink alcohol? ☐ Yes ☐ No If yes, how much, what kind, and how often?_________________________

____

Breakfast

Do you typically eat breakfast every morning? ☐ Always ☐ Sometimes ☐ Never

Approximate time:____________________ Examples of foods you eat for breakfast:___________________________

____

____

Do you typically eat snacks before lunch? ☐ Always ☐ Sometimes ☐ Never

Approximate time:____________________ Examples of foods you eat for snacks:_____________________________

____

Lunch

Do you typically eat lunch every day? ☐ Always ☐ Sometimes ☐ Never

Approximate time:____________________ Examples of foods you eat for lunch:______________________________

____

____

Do you typically eat snacks before dinner? ☐ Always ☐ Sometimes ☐ Never

Approximate time:____________________ Examples of foods you eat for snacks:_____________________________

____

Dinner

Do you typically eat dinner every day? ☐ Always ☐ Sometimes ☐ Never

Approximate time:____________________ Examples of foods you eat for dinner:______________________________

____

____

Do you typically eat snacks after dinner? ☐ Always ☐ Sometimes ☐ Never

Approximate time:____________________ Examples of foods you eat for snacks:_____________________________

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