ELEVATED HEALTH

New Patient Intake Form

Please have filled out for your one-on-one with Dr. Tyler Elmore

Basic Patient Information

Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Sex: M F Age: _____ Birth date: _____ Height: _____ Weight: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation: _____ Hobby: _____

Who may we thank for referring you? _____

Name of M.D. if currently under care? _____

Medical Prescriptions: _____

Has your doctor advised you to lose weight? ☐ Yes ☐ No

Do you have any dietary restrictions? ☐ Yes ☐ No

Check ALL that apply to you: ☐ Heart Condition ☐ Epilepsy/Seizures ☐ Pregnant ☐ Might Be Pregnant

☐ Taking Heart Medication/Blood Thinners ☐ Currently Undergoing Chemotherapy ☐ Breast Feeding

☐ Known Adverse Reactions to Niacin or B Vitamins

Health and Wellness History

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

Check ALL areas of treatment that interest you:

☐ Weight Loss ☐ Cleansing and Detoxification ☐ Overall Health ☐ Body Wraps

☐ Improving Energy ☐ Stress Reduction ☐ Better Sleep ☐ Other

Did you know that all of the treatments listed above are 100% safe? ☐ Yes ☐ No

Have you received treatment for any of the above? ☐ Yes ☐ No

When was the last time you were at your goal weight? _____

What do you consider your ideal weight? _____

How much weight do you want to lose? _____

How many times a year do you diet? _____

What is stopping you from losing weight all on your own? _____

What have you tried in the past that has failed? _____

Does your weight problem make you physically uncomfortable? ☐ Yes ☐ No

Please explain: _____

Does your weight problem cause physical pain? ☐ Yes ☐ No

Please explain: _____

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Health and Wellness History (Continued)

Are you embarrassed by your excessive weight? □ Yes □ No

Please explain: _____

Does being overweight and unhealthy limit your activities? □ Yes □ No

Please explain: _____

Do you binge eat? □ Yes □ No

Do you suffer from uncontrollable cravings? □ Yes □ No

Do you feel food controls you? □ Yes □ No

Do you eat for emotional reasons (stress, anger, sadness, etc.)? □ Yes □ No

Do you eat between meals? □ Yes □ No

What do you choose to eat between meals? _____

Briefly describe your daily eating behavior: _____

Do you feel your eating behavior is normal? □ Yes □ No

Do you feel tired, run down, and out of energy? □ Yes □ No

Is successful weight loss a top priority? □ Yes □ No

How fast do you want to be slim, trim, and fit? _____

What's more important to you fast or permanent? _____

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

Is your family excited about you coming here for weight loss? □ Yes □ No

Can you remember being your ideal weight? □ Yes □ No

What do you remember most about it? _____

_____

What is the most important element for you in deciding to use our services?

Circle only ONE of the four answers.

EFFECTIVENESS:	"My results are my top priority."
TIME:	"I want results quickly."
SERVICE:	"I need extra support along the way."
AFFORDABILITY:	"What you charge is my concern."

I understand that my entire patient record will remain completely confidential and will not be released without express written consent from me.

Signature: _____ Date: _____