**Weight Loss New Patient Form**

Dr. Sophie Jacob’s Weight Loss Center

Name: Birth Date:

Address: City/State: Zip Code:

Cell#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home#\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Work#:

Email: Occupation:

**How did you hear about our weight loss program?** *(Please Circle)*

*Email Facebook Postcard Handout Mail Poster/Sign*

*Friend Radio TV ad Dr. Sophie Front Desk Weight loss talk*

**Health and Wellness History**

Has your doctor advised you to lose weight?

Do you have any dietary restrictions?

Are you taking any medication?

How often do you exercise?

What type of exercise do you do?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Daily** | **3 or more per week** | **1-2 times per week** | **1-2 times per month** | **Less than once a month** | **Never** |
| Standing or Walking : |  |  |  |  |  |  |
| Work or Sit at a Desk : |  |  |  |  |  |  |
| Moderate/Heavy labor : |  |  |  |  |  |  |
| Tobacco/Smoke : |  |  |  |  |  |  |
| Alcoholic beverages : |  |  |  |  |  |  |
| Caffeine / Energy drinks: |  |  |  |  |  |  |

**Check ALL areas of treatment that interest you:**

* Weight Loss
* Cleansing and Detoxification
* More Energy
* Cellulite Reduction
* Non-Invasive   
  Lipo Laser

Do you know that all treatments listed above are 100% safe? 🞎 YES 🞎 NO

Have you ever used any of the above treatments before? 🞎 YES 🞎 NO

What do you consider to be your ideal weight?

How much weight do you want to lose?

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

*~ Turn Over To Complete ~*

How many times a year do you diet?

What is stopping you from losing weight on your own?

List of surgeries?

Does your weight problem make you physically uncomfortable? 🞎 YES 🞎 NO

Does your weight problem cause you physical pain? 🞎 YES 🞎 NO

Are you embarrassed by your excessive weight? 🞎 YES 🞎 NO

Do you binge eat? 🞎 YES 🞎 NO

Do you suffer from uncontrollable cravings? 🞎 YES 🞎 NO

Do you eat because of your emotions? 🞎 YES 🞎 NO

Do you eat between meals? 🞎 YES 🞎 NO If yes, what do you eat?

Do you feel that your eating behaviors are normal? 🞎 YES 🞎 NO

How often do you feel tired, or out of energy?

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

Is Successful weight loss a top priority? 🞎 YES 🞎 NO

**Check the following conditions you want help with or more information on:**

* Cleansing
* Cellulite
* Hormone Balance
* Neuropathy
* Pain Relief
* Quit Smoking
* Weight Loss
* Thyroid

**What is the MOST important element in deciding to use our services?**

Effectiveness: “My results are my top priority”

Time: “I want results quickly”

*Circle only ONE*

*of the four answers*

Service: “I need extra support along the way”

Affordability: “I need this to be affordable”

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

Signature: Date:

*For Doctors Use Only:*

**Current Weight** **BMI**:

Age Height **Ph:**  **FAT%:**

Kids # Pregnant? Yes / No Spouse / Other Name

**Measurements**

Back: Hips: Mid-Abdomen (Belly Button):

Waist: Left Thigh: Right Thigh:

*Rev. 01/10/2020 (WL:FORMS:NEW PATIENT FORM)*

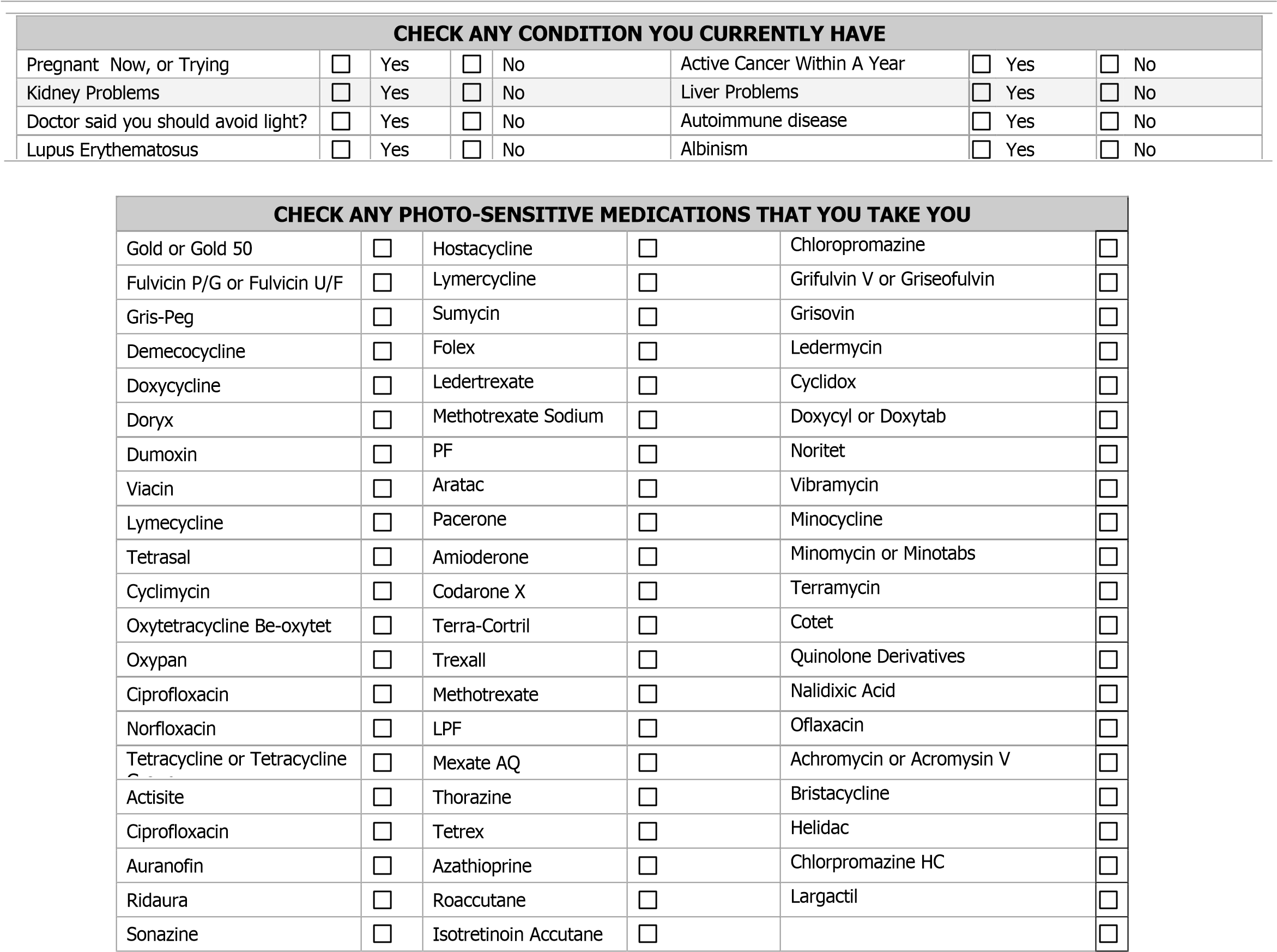
**Real people. Real results. Guaranteed.**

1-800-345-4381

Info@MyUltraSlim.com

# HEALTH HISTORY QUESTIONNAIRE

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name** (Last, First, M.I.): |  |  |  | M F | **DOB:** |
| **Home Address :** |  |  |  |  | **Phone:** |
| **Email:** |  |  |  |  |  |
| **Location of Services:** |  |  |  |  |  |



\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

Rev. 01/10/2020

**Where Healing Begins Naturally, L.L.C.**

Dr. Sophie Jacob, D.C.

**4713 N. 1st Ave.**

**Tucson, Arizona 85718**

PHONE: (520) 891-2882 FAX: (520) 308-4457

dcsophie30@hotmail.com

***ACKNOWLEDGEMENT OF RECEIPT OF***

***NOTICE OF PRIVACY PRACTICES***

***You may Refuse to Sign This Acknowledgment***

***I, , have received a copy of this Office’s notice of Privacy Practice***

***Signature Date***

***For Office Use Only***

***We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices,***

***but acknowledgement could not be obtain because:***

***□ Individual refused to sign***

***□ Communication barriers prohibited obtaining the acknowledgement***

***□ Other (Please Specify):***

***24 HOUR APPOINTMENT POLICY***

**\*\*\**We would appreciate 24 hours advance notice in the event you are unable to keep your scheduled appointment or have the need to reschedule. \*\*\****

Please note that a charge of $25.00 for any missed appointment without a 24 hour notice will be enforced.

**We are committed to your health and well-being, and we thank you for your cooperation in this regard.**

**By signing you agree to the terms and conditions stated above.**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**