MINNETONKA
WEIGHT LOSS

New Patient Form

Name _____ Referred by _____ Date _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Email Address _____

Emergency Contact _____ Relationship to you _____

Height _____ Weight _____ Date of Birth _____ Age _____ Sex _____

Marital Status _____ Are you pregnant? ☐ No ☐ Yes, how far along? _____

Occupation _____ How many hours do you work per week _____

Do you experience any of the following conditions, even if they are minor and go away on their own?

☐ High Blood Pressure	☐ Diabetes	☐ Headaches	☐ Hypoglycemia
☐ Cancer	☐ Neck Pain	☐ Back Pain	☐ Thyroid Problems
☐ Heart Disease	☐ Digestive Problems	☐ Arthritis	☐ Chronic Fatigue
☐ Fibromyalgia	☐ Numbness	☐ Stress/Irritability	☐ Sinus/Allergy
☐ Hip/Knee Pain	☐ Osteoporosis	☐ Chronic Inflammation	☐ Other

Are you currently on any medications? If so, please list:

_____

Are you currently taking nutritional supplements? If so, please list:

_____

How much water do you consume per day? _____ What type? ☐ Filtered ☐ RO ☐ Tap ☐ Bottled

How stressed are you? (on a scale of 1 to 10, where 10 is the worst) _____

Do you exercise? ☐ No ☐ Yes, how often? _____ What type? _____

How long have you been overweight? _____ How much weight do you want to lose? _____

How important is weight or size reduction to you? (on a scale of 1 to 10, where 10 is the most important?_____

What have you tried in the past for weight loss or detoxification?_____

Does your weight cause physical pain? If yes, please explain: _____

How fast would you like to be trim and fit?_____

Which do you want us to focus on? ☐ Abdomen ☐ Buttocks ☐ Thighs ☐ Chest ☐ Arms ☐ Neck ☐ Cellulite

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Do you eat because of your emotions? ☐ No ☐ Yes

Do you eat between meals? ☐ No ☐ Yes

Does being overweight limit your activities? ☐ No ☐ Yes

Do you eat fast foods, pre-packaged foods or fried foods on a regular basis? ☐ No ☐ Yes

Do you drink coffee, sodas or energy drinks during the day to "get yourself going"? ☐ No ☐ Yes

Do you crave sugary snacks, candies or desserts? ☐ No ☐ Yes

Do you smoke cigarretes or chew tobacco? ☐ No ☐ Yes

Have you experienced yeast or fungal infections? ☐ No ☐ Yes

Do you live in a large city, near a freeway or factories? ☐ No ☐ Yes

Do you use fluride toothpaste or drink fluridated/chlorinated water? ☐ No ☐ Yes

Have you worked in a toxic environment (exposure to fumes from chemicals, sprays, paints, or plastics)? ☐ No ☐ Yes

Do you use hairspray, perfumes, cosmetics, deodorants with aluminum chlorohydrate, or nail polish? ☐ No ☐ Yes

Do you have a household pet or work around animals? ☐ No ☐ Yes

Do you use strong chemical cleaners in your home? ☐ No ☐ Yes

Have you had your yard or home sprayed for insects in the past or recently? ☐ No ☐ Yes

Do you eat lots of non organic fruits and vegetables? ☐ No ☐ Yes

Do you feel run down or out of energy? ☐ No ☐ Yes

Check all areas of treatment that interest you:

☐ Weight Loss ☐ Cleansing and Detoxification ☐ General Wellness ☐ More Energy ☐ Stress Reduction

Other _____

What are your desired health outcomes and why?

Your Name (print) _____

Signature _____ Date _____

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