ND LIFE SPA.COM

New Patient Intake Form

Basic Patient Information

Name: ______________________________ Date: ________________

Street Address: ____

City: ____________________ State: ________________ Zip: __________

Home Phone: ______________ Cell Phone: ________________________

Email Address: ____

Sex: M F Birth Date: ________ Height: ________ Weight: ____________

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

Occupation: ____

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 the 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 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 you goal weight? ____________________

How much weight do you want to lose? ______________________________

Health and Weight Loss Concerns (Continued)

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: ____

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 form emotional reasons (stress, anger, sadness, etc.)? ☐ Yes ☐ No

Do you 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: ____________________