DiscoverPro
Inspire Wellness

NEW CLIENT QUESTIONNAIRE

Full name: ____ Today's date: ___________________________

Preferred name: ___________________________ Marital status: single / married / divorced / widowed / other

Address: ____ City: _____________________ State: ______ Zip: ____________

Contact number: _____________________________ E-mail address ____

Gender: Male Female Birth date: ________________________ Social Security #: _____________________________

Occupation: _____________________________ Employer name: ____

Emergency contact name: _______________________________ Phone: _________________ Relationship ________________

Primary physician: ____________________________Office: _________________________ Date of last visit: _______________

How did you hear about us? ____

What is your current weight? ______________ Height? ____________

What is your current activity level? LOW MODERATE HIGH

What is your "Goal Weight"? _____________________ When was the last time you weighed that? ___________________

Has your doctor recommended you to lose weight? YES NO

Have you tried to lose weight in the past? YES NO If "YES", please describe: ____

____

What are your top 2 specific reasons why you want to lose weight, improve your health and live well?

1. ______________________________________ 2. ____

On a scale of 1-10, with 10 meaning "I'M SERIOUS ABOUT LOSING WEIGHT AND FULLY COMMITTED" what is your current level of commitment? 1 2 3 4 5 6 7 8 9 10

YOUR HEALTH SUMMARY

Please ✓ check all symptoms you have ever had (S=self), even if they do not seem related to your current problem, and mark (F=family) if you have a family history of any of them.

S F	S F	S F	S F
☐ ○ Stroke	☐ ○ Epilepsy	☐ ○ Headaches	☐ ○ Depression
☐ ○ Heart Attack	☐ ○ Hypoglycemia	☐ ○ Neck Pain/Stiffness	☐ ○ Mood Swings
☐ ○ Diabetes	☐ ○ Pacemaker	☐ ○ Back Pain/Stiffness	☐ ○ Stress
☐ ○ Thyroid Disease	☐ ○ Organ Transplant	☐ ○ Loss of Balance	☐ ○ Poor Sleep
☐ ○ Gallbladder Disease	☐ ○ Intestine problems	☐ ○ Dizziness	☐ ○ Fatigue
☐ ○ Kidney Disease	☐ ○ Constipation	☐ ○ Arthritis	☐ ○ Hot Flashes
☐ ○ Liver Disease	☐ ○ Stomach	☐ ○ Skin Conditions	☐ ○ Cold Feet
☐ ○ High Blood Pressure	☐ ○ Heartburn	☐ ○ Hair Loss/Thinning	☐ ○ Hysterectomy
☐ ○ High Cholesterol	☐ ○ Gout	☐ ○ Bipolar Disorder	☐ ○ Anxiety
☐ ○ Shortness of Breath	☐ ○ Cancer (Type: ____)		

(PLEASE TURN OVER AND COMPLETE OTHER SIDE.)

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HEALTH SUMMARY – PAGE 2

List any medications you are taking & what for: ____

____

List any major hospitalizations, operations or illness: ____

____

Have you been treated by a physician in the last 12 months? **YES NO**

If "YES", please describe: ____

Are you under regular chiropractic care? **YES NO** (Supports neuroendocrine system)

In addition to weight loss, if there was one other health condition or struggle that you would love to see your body heal and/or overcome, what would that be? ____

Please Circle Yes or No to Answer the Questions Below:

YES NO Are you currently taking either, Steroids, Estrogen or undergoing any Hormone Replacement Therapy?
If yes, please explain ____

YES NO Are you currently taking any blood thinners? If yes, please explain ________________________________

YES NO Do you have heart problems? If yes, please explain ____

YES NO Do you take insulin for diabetes? If yes, please explain ______________________________________

YES NO Do you suffer from mental illness including anxiety/depression?
If yes, please explain ____

YES NO Are you or have you been suffering from an eating disorder? If yes, please explain _____________________

YES NO Have you had a serious health complications attempting a detox, weight loss or lifestyle program in the last five years?
If yes, please explain ____

Females only

YES NO Are you pregnant?

YES NO Are you breast feeding?

YES NO Are you on birth control?

PRIMARY CARE MEDICAL WAIVER

I understand that the information I provided on this document is relative to my capacity of completing any lifestyle program designed and implemented by your establishment and answering ***YES*** *to any of the questions above shall require further discussion with my primary care physician and clearance prior to initiating such program.*

I further acknowledge and agree that, I waive any claims I may have against your establishment, or any of your employees, or agents and agree to hold you harmless and indemnify your establishment, your employees, or agents from and against any and all claims, damages, causes of action or injuries relating to any of the lifestyle programs I enroll in because I understand it is my responsibility to:

1. Complete this form with accuracy and to disclose any related information to the questions I completed with integrity.

2. Consult with my primary care physician on any medications, supplements, product interactions, historical and present medical conditions, diagnoses and treatment, prior to, during, and after completing any lifestyle program.

3. I will provide any documentation from my primary care physician to your establishment should it be in relation to the lifestyle program, directly or indirectly.

CLIENT SIGNATURE ____ **DATE** ____________________

PRINT CLIENT NAME ____