COMPREHENSIVE HEALTHCARE
CHC REGENERATIVE MEDICINE

Health Risk Anaylsis

Today's Date: DOB: Age: Height: Weight:

Name Gender: ☐ Male ☐ Female
(Last) (First)

Mailing Address:

City: State: Zip:

Email Address:

Home Phone: Work Phone: Mobile:

How did you hear about us? If referred by someone, who?

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

What made you decide to do something about your weight today?

Who encouraged you to lose weight? Can you commit to one visit a week? ☐ Yes ☐ No

What important reason, special occasion, or goal date do you have for wanting to lose weight?

How important to you is it that you lose weight?

How many pounds would you like to lose? How fast do you want to be slim, trim & fit?

Have you ever attended any other weight reduction centers, if so, which ones?

What kinds of diets have you tried on your own?

What is the longest you have been able to stick with a diet?

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

Have you been advised by your family physician to lose weight? ☐ Yes ☐ No

If yes, what is your doctor's name?

Do you eat because of emotions? ☐ Yes ☐ No If yes, please explain:

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On average, which of the following reflects your daily eating habits? **(Please check all that apply.)**

- ☐ 3 meals with healthy snacks
- ☐ 3 meals
- ☐ 2 meals or less
- ☐ Skip breakfast or other meals
- ☐ Generally eat on the run
- ☐ No regular eating pattern
- ☐ often crave sweets/carbs
- ☐ Graze; small, frequent meals *(How many per day?* _____ *)*

Please check your current level of exercise:

- ☐ **None**
- ☐ **Light exercise:** 1-3 times per week, easy pace, stretching, walking, etc.
- ☐ **Moderate exercise:** 2-3 times per week, moderate pace, some weights, etc.
- ☐ **Heavy exercise:** 3-4 times per week, vigorous pace, weights, fast running, etc.

Health Information

Past or Present Health Conditions:

DIABETES:	☐ Yes	☐ No	HORMONE IMBALANCE:	☐ Yes	☐ No
HYPOGLYCEMIA:	☐ Yes	☐ No	THYROID IMBALANCE:	☐ Yes	☐ No
STROKES:	☐ Yes	☐ No	ANOREXIA:	☐ Yes	☐ No
HEART DISEASE:	☐ Yes	☐ No	BULIMIA:	☐ Yes	☐ No
HIGH BLOOD PRESSURE:	☐ Yes	☐ No	DRUG ADDICTION:	☐ Yes	☐ No
PCOS: (polycystic ovarian syndrome)	☐ Yes	☐ No	Hysterectomy (Full/Partial)	☐ Yes	☐ No

Current or previous Cancer ☐ Yes ☐ No ((Name of Cancer) _____

ARE YOU CURRENTLY PREGNANT OR NURSING? ☐ Yes ☐ No

ARE YOU ALLERGIC TO SULFA, FOOD OR MEDICATION? ☐ Yes ☐ No

If you answered YES to any of the above, please explain: _____

Have you ever been hospitalized, under medical care, or checked into rehab for alcohol or drug treatment? ☐ Yes ☐ No

If YES, please explain: _____

Please list any and all medications you are currently taking, **including doses and reason for taking:**

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Confidential Patient Information

Name: _____ Email: _____

Check off any of the following symptoms you have experienced in the past 6 months:

- ☐ Low Back Pain
- ☐ Pain between Shoulder Blades
- ☐ Neck Pain
- ☐ Tension/Headaches
- ☐ Fibromyalgia
- ☐ Tension Across Top of Shoulders
- ☐ Numbness/Tingling in Arms/Hands
- ☐ Numbness/Tingling in Legs/Feet
- ☐ Pain in the legs
- ☐ Pain in the feet
- ☐ Tired/Fatigued
- ☐ Difficulty Sleeping
- ☐ Allergies
- ☐ Digestive Problems
- ☐ Carpal Tunnel

OTHER (explain)_____

Which of the above is the worst?_____

How long have you had it? _____

How often does it occur? _____

What does it feel like? (Describe) _____

What have you done that has helped this problem?_____

What activities would you like to do if this was not a problem?_____

Does this cause you to be:

- ☐ Moody
- ☐ Irritable
- ☐ Interrupt sleep
- ☐ Restricted in your daily activities

Does this affect your work:

- ☐ Decision making
- ☐ Poor attitude
- ☐ Decreased productivity
- ☐ Exhausted at the end of the day
- ☐ Unable to work long hours

Does this affect your life:

- ☐ Lose patience with spouse/children
- ☐ Restricted household duties
- ☐ Hinders ability to exercise or sports
- ☐ Interferes with ability to do hobbies or other activities

What have you tried to help relieve/get rid of this problem and how much did it help? (Check all that apply)

- Medications.. Helped: ☐ Little ☐ Some ☐ Much
- Physical Therapy... Helped: ☐ Little ☐ Some ☐ Much
- Chiropractic... Helped: ☐ Little ☐ Some ☐ Much
- Exercise Helped: ☐ Little ☐ Some ☐ Much
- Nutrition... Helped: ☐ Little ☐ Some ☐ Much
- Stretching... Helped: ☐ Little ☐ Some ☐ Much

OTHER _____

Location: _____ Date: _____ Apt: _____

I consent to receiving a health screening. I realize that I am not receiving a diagnosis, treatment or prognosis for any condition that I may be experiencing. I acknowledge that I am receiving a demonstration only and agree to hold harmless the therapist and/or clinic from any damage resulting from this demonstration.

Signature: _____ **Date:** _____

How did you hear about us? _____

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Do you have health insurance? ☐ Yes ☐ No **What kind?** _____

Please list any symptoms you experience that were not previously mentioned: _____

_____

What is the most important factor in deciding to use our services? **(Select only one)**

- ☐ **EFFECTIVENESS:** "My results are my top priority."
- ☐ **TIME:** "I want results quickly."
- ☐ **SERVICE:** "I need extra support along the way."
- ☐ **EASE:** "I have a difficult time losing weight."

I understand that my patient file will be kept completely confidential unless I give written permission for my information to be released.

Signature: _____ **Date:** _____

FOR OFFICE USE ONLY:

Initial Weight _____ Age _____ Height _____ Ideal Weight _____ Must Lose _____

Treatment Weeks _____ 1/2 Way Point _____ Goal Date _____

Initial Body Fat % _____ BMI _____ Waist _____

Program Director _____

BP: _____ / _____ **Pulse** _____ **Temp:** _____