Evolution Health Center
"Evolutionary Chiropractic Care & Weight Loss"
By Main Street Chiropractic
T: (302) 390-2402 E: contact@evolvechirocare.com

Evolutionary Weight Loss Intake Form

Patient Information:

Full Name: ____

Date of Birth: _______________ Age: _____ Gender: _________

Phone: ______________________ Email: __________________

Address: ____

Emergency Contact: _______________ Phone: _______________

Medical History:

Do you have any current medical conditions? (Please specify):

____

____

Do you have any allergies? (Please specify): _____________________

Are you currently taking any medications or supplements? (Please specify):

____

____

Have you had any surgeries in the past? (Please specify):

____

____

Weight Loss Information:

What is your current weight? ____________ lbs/kg

What is your goal weight? ____________ lbs/kg

Where would you like to lose weight or contour your body? (Please check all that apply)

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[ ] Abdomen [ ] Arms [ ] Back [ ] Buttocks [ ] Chin/Jawline [ ] Hips/Thighs [ ] Love handles [ ] Neck [ ] Other: ________________

Have you tried any weight loss programs in the past? (Please specify):

____

____

Nutrition Information:

On average, how many meals per day do you eat? _______

Do you have any dietary restrictions or preferences? (Please specify):

____

____

Do you have any specific nutritional goals? (Please specify):

____

____

Other Information:

How did you hear about Evolution Health Center? (Please check all that apply)

[ ] Internet search [ ] Referral from a friend/family member [ ] Social media [ ] Advertisement [ ] Other: ________________

Is there anything else we should know about your health or weight loss goals?

____

____

Patient Signature_______________________ Date________________________

Thank you for filling out this form. If you have any questions or concerns, please do not hesitate to ask our staff.