EAST VILLAGE | PHYSICAL MEDICINE
Stop pain. Start living.

SlimShift Medical Weight Loss Intake Form

Patient Information

First name: ____________ Last name: ____________ Date: ____________

Date Of Birth: ____________ Gender ◯ Male ◯ Female ◯ Other

Phone Number ____________ Email ____________

Height: ____________ Weight: ____________

Address ____________

State: ____________ Zip Code: ____________

Referral Information

Who may we thank for referring you to our office?

◯ Friends or family ◯ Healthcare provider ◯ Online Search

◯ Wellness Class ◯ Other: ____________

Medical History

Do you or any family member have/had any of the following? (Check all that apply):

◯ Depression ◯ Thyroid Disease ◯ Stroke ◯ Hypoglycemia

◯ Heart attack ◯ Gallbladder Disease ◯ Fatigue ◯ Anemia

◯ Diabetes ◯ Kidney Disease ◯ Brain Fog ◯ Cancer

◯ High Blood Pressure ◯ High Cholesterol ◯ Poor Sleep ◯ Weight Gain

◯ Intestinal Problems ◯ Headache ◯ Dizziness ◯ Back pain

◯ Shortness of Breath ◯ Neuropathy/ Nerve Problems ◯ Arthritis ◯ Carpal Tunnel

Is there a certain time of day any of these problems are better or worse?

____

Are You taking any medications/ supplements?

◯ Yes ◯ No

If Yes, Please List: ____________

____

Are you pregnant?

◯ Yes ◯ No

How Many Children? ____________

How Many Pregnancies? ____________

Are you breast-feeding?

◯ Yes ◯ No

Any known allergies?

◯ Yes ◯ No

If Yes, Please List: ____________

____

____

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Main Concerns

1. ______
2. ______
3. ______

How long have you had this/these concerns?

______

What effect does this have on your body functions or quality of life?

______

What would be different or better without this/these concerns?

- ☐ Diminished Stress
- ☐ More Energy
- ☐ Improved Self-Esteem
- ☐ Confidence
- ☐ Sleep
- ☐ Work
- ☐ Family
- ☐ Outlook/ Mindset

Health and Lifestyle

How have you addressed weight management in the past? (Check all that apply):

- ○ Friends or family
- ○ Healthcare provider
- ○ Online Search
- ○ Wellness Class
- ○ Other: ______

How did the previous methods work for you?

______

What potential barriers do you foresee that would prevent the change you are looking for?

______

Do you feel it possible to eliminate or prevent these potential barriers? ○ Yes ○ No

What outcome would you like to see for this to be a success for you?

______

______

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Mind & Body Balance

Energy Level:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Quality of Sleep:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How Important It Is For You To Resolve Your Health Concerns:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What Is Your Level of Preparedness To Make Necessary Lifestyle Changes To Achieve Your Goals?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

I am interested in

○ Weight loss
○ Anti-Aging
○ Inch Loss
○ Metabolism Support
○ Long Term Results

____
____
____