

# NATURAL YOU

## HEALTH SPA

*Nature Meets Innovation™*

### NEW PATIENT INTAKE FORM

Please fill out this confidential form as detailed as possible.  
*Your success is our #1 priority but this takes your commitment as well.*  
We will review this with you during your initial consultation.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Cell phone number (with area code): \_\_\_\_\_ Carrier \_\_\_\_\_

Your email address: \_\_\_\_\_

What is your profession, or where do you work? \_\_\_\_\_

Are you generally sitting at work or is there physical labor? \_\_\_\_\_

Hobbies: \_\_\_\_\_

How did you hear about us? newspaper\_\_\_ radio\_\_\_ magazine\_\_\_ flyer\_\_\_ other\_\_\_\_\_

Or did a friend refer you to us? \_\_\_\_\_ If yes, who sent you? \_\_\_\_\_

Where do they work? \_\_\_\_\_ What's their phone # \_\_\_\_\_

*We want to be sure to thank them with a gift for the referral! (and we will do the same when you refer a friend!)*

Your Real Age \_\_\_\_\_ Is this the age you feel? Y/N Younger or Older \_\_\_\_\_

Height \_\_\_\_\_ Current Weight \_\_\_\_\_

What body area(s) do you want to tackle? \_\_\_\_\_

What do you want to weigh, or what clothing size do you want to reach? \_\_\_\_\_

Any idea on how many inches you want to lose and from where? \_\_\_\_\_

How soon do you want to reach that goal? \_\_\_\_\_

Does your family and or friends support you in your health goals?

Circle what applies:      100% support              not really supportive              I could use a support system

What's your biggest struggle related to your health, weight loss, or healthy eating \_\_\_\_\_  
\_\_\_\_\_

These treatments can take a minimum of 6 weeks of consistent visits, 2 times a week.

Do you have any upcoming extended trips planned in the next 60 days?    yes/no

Are you currently under the care of any doctor? \_\_\_\_\_ If yes, why? \_\_\_\_\_

Have you had any recent surgery? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

What ways have you tried losing weight in the past? List products, companies, programs.

\_\_\_\_\_  
\_\_\_\_\_

Have you ever had any procedure for weight loss? \_\_\_\_\_

Do you feel like nothing ever permanently works when it comes to weight loss? \_\_\_\_\_

If yes, why? \_\_\_\_\_

Are you currently a member of a gym? \_\_\_\_\_

Do you regularly exercise? \_\_\_\_\_ How often in a week? \_\_\_\_\_

What do you do for exercise? \_\_\_\_\_

To help flush the fat, you **MUST** exercise at least 6 days a week for a minimum of 30 minutes, even if it's a brisk walk through your neighborhood? Will you?    yes/no

Could you benefit from  
Improved nutrition?    yes/no

Having more energy?    yes/no

Sleeping better at night?    yes/no

Do you have a hard time getting out of bed in the morning?    yes/no

Do you have any aches or pains?    yes/no    What hurts? \_\_\_\_\_

Do you take naps?    yes/no    If yes, how often? \_\_\_\_\_

How often do you eat fast food? \_\_\_\_ How many times a week? \_\_\_\_\_

List the fast food places where do you often eat \_\_\_\_\_

What do you usually order? \_\_\_\_\_

What do you regularly drink? Circle all that apply.

milk    coffee    water    soda    energy drinks    juice    wine    beer    liquor    other:

Of those you circled, how many glasses or cups do you have in an average day.

Please write the number of glasses or cups below the drink above.

List any and all medications you are currently taking. *(This matters when it comes to weight loss.)* \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any vitamins, herbs or supplements you take on a regular basis.

\_\_\_\_\_  
\_\_\_\_\_

Do you have any daily aches and pains? Please list those below.

\_\_\_\_\_