DiscoverPro Questionnaire

Full Name: ______________________________ Today's Date: ______________

Preferred Name: ______________ Marital Status: Single, Married, Divorced, Widowed, Other

Address: ______________________ City: __________ State: _____ Zip: ______

Home ( ) ___________ Work ( ) ____________ Cell ( ) ____________

Email Address: ___________________________ Male ________ Female ______

Social Security # _________________ Birth Date: _______________ Height: _____

Occupation: ___________________ Employer Name: ______________________

Spouse: _______________ Your Activity Level: ( ) Low ( ) Moderate ( ) High ( ) Intense

Would you like appointment reminders? Yes No

If yes, ( ) Email ( ) Text to cell (service provider: ________________________)

YOUR HEALTH SUMMARY

Please ☑ check all symptoms YOU have ever had [self=S], even if they do not seem related to your current problem, & mark [family=F] if you have a FAMILY history of any of them, like this ✓

S F		S F		S F		S F	
❑ ( )	Stroke	❑ ( )	**Epilepsy**	❑ ( )	Headaches	❑ ( )	Mood Swings
❑ ( )	Heart Attack	❑ ( )	**Hypoglycemia**	❑ ( )	Neck Pain	❑ ( )	Loss of balance
❑ ( )	Diabetes	❑ ( )	**Pacemaker**	❑ ( )	Poor Sleep	❑ ( )	Nervousness
❑ ( )	Thyroid Disease	❑ ( )	**Organ Transplant**	❑ ( )	Dizziness	❑ ( )	Stomach upset
❑ ( )	Gallbladder Disease	❑ ( )	High Blood Pressure	❑ ( )	Arthritis	❑ ( )	Tension
❑ ( )	Kidney Disease	❑ ( )	Intestine Problems	❑ ( )	Mid Back Pain	❑ ( )	Cold feet
❑ ( )	Depression	❑ ( )	Shortness of Breath	❑ ( )	Lower Back Pain	❑ ( )	Hot flashes
❑ ( )	Gout	❑ ( )	High Cholesterol	❑ ( )	Cancer (Type: _____)	❑ ( )	Heartburn

List any medications you are taking & what for: ______________________________

____

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? ____________________

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

How long have you been overweight? _____ Have you tried to lose weight in the past? ( )Yes ( )No

What are your top 2 reasons why you want to lose weight?

1. ______________________ 2. ______________________

Has your doctor recommended you to lose weight? ( ) Yes ( ) No

What is your "Goal Weight"? ________ When is the last time you weighed that? __________

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

Females: Are you pregnant? ( ) Yes ( ) No Are you breast feeding? ( ) Yes ( ) No

Are you on birth control? ( ) Yes ( ) No Do you have an estrogen patch or implant? ( ) Yes ( ) No