One Light™
Chiropractic & Weight Loss

DOCTOR SUPERVISED CHIROTHIN WEIGHT LOSS PROGRAM

Weight Loss Intake Form

Name _____ D.O.B. _____/_____/_____ Age _____ Sex ○ M ○ F

Address _____City/State/Zip_____

Best Phone _____☐Cell? Email _____

Status ☐M ☐S ☐D ☐W Number of Children _____ Previous Chiropractic Care ○ N ○ Y When?_____

Occupation _____ Referred By _____

What are your reasons for wanting to lose weight?

How much weight would you like to lose? _____ lbs

Describe how will you **feel** when you accomplish this goal? *(example: more confident, "light," more motivated, happy)*

How will accomplishing this goal improve your life? *(example: better intimacy, easier to exercise, travel and play with your kids/grandkids, etc.)*

What does it **feel** like in your body now? *(example: fatigued, easily winded, feel like a blob, don't want to go out, hate the scale/clothes/mirror etc.)*

What does your current weight prevent you from enjoying in life?

Please list in order of preference (1 - 4) with 1 being most important, what you value most in a weight loss program.

_____ Rapid and noticeable loss of weight and inches

_____ Feeling supported by a knowledgeable team

_____ Developing a long term trusted relationship with our health care team for life-long health related advice

_____ Learning proven methods for weight loss and long term age management.

If you have ever tried to lose weight before, please describe what you have done and the results you achieved.

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Are you currently pregnant, breast feeding, have active cancer, or cholecystitis? ◯ Yes ◯ No

Do you experience any of the following conditions even if they are minor and go away on their own?

- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Heart Disease
- ☐ Fibromyalgia
- ☐ Hip/Knee Pain
- ☐ Diabetes
- ☐ Neck Pain
- ☐ Digestive Problems
- ☐ Numbness
- ☐ Osteoporosis
- ☐ Headaches
- ☐ Upper/Low Back Pain
- ☐ Arthritis
- ☐ Stress/Irritability
- ☐ Chronic Inflammation
- ☐ Hypoglycemia
- ☐ Thyroid Problems
- ☐ Chronic Fatigue
- ☐ Sinus/Allergy
- ☐ Other

Family History – Please indicate any of your relatives who have had any of the following conditions:

- ☑ Alcoholism _____
- ☐ Anemia _____
- ☐ Arthritis _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Emphysema _____
- ☐ Epilepsy _____
- ☐ Glaucoma _____
- ☐ High BP _____
- ☐ Stroke _____
- ☐ Heart Disease _____
- ☐ Osteoporosis _____
- ☐ Mental Illness _____
- ☐ Other _____

Please list any medications you are taking & what they are treating.

1. _____
2. _____
3. _____

Please list any vitamins and natural supplements you are taking.

_____ _____

_____ _____

_____ _____

Please use this area to describe any significant emotional trauma, injuries/accidents & approximate age they occurred.

1. _____ Age _____
2. _____ Age _____
3. _____ Age _____
4. _____ Age _____
5. _____ Age _____
6. _____ Age _____

Other:

Do you have any other health challenges that you feel are important for us to know about?

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CHIROTHIN WEIGHT LOSS PROGRAM INFORMED CONSENT AND RELEASE OF LIABILITY

I understand that my use and consumption of any ChiroThin product or engaging in any weight loss program including the type that is to be used in conjunction with ChiroThin, have inherent risks to my health and well-being, including but not limited to headaches, nausea, dizziness, vomiting, fatigue, pain, loss of consciousness, shortness of breath and other ailments. I understand as well that rapid weight loss of over 1-2 lbs. per week is considered by most in the weight loss medical community to be excessive and may lead to ailments similar and in addition to those mentioned above. Therefore, I understand that my failure to follow the weight loss program exactly as described to me by my physician or chiropractor can result in severe temporary and/or permanent medical conditions in addition to those mentioned above.

I understand that I will not use or consume any of the ChiroThin products if I am pregnant or think I might be pregnant. I understand that, as a dietary supplement, ChiroThin has not been approved by the FDA or any Federal or State authority. I additionally understand that The ChiroThin Weight Loss Program is not meant to diagnose, treat or cure any disease or medical condition and that I am to undergo participation in the ChiroThin Weight Loss Program only under doctor supervision. I also understand that I should consult with my doctor prior to starting ANY exercise or nutritional supplement program.

I understand that, if I experience any ailment, including but not limited to headaches, nausea, dizziness, vomiting, fatigue, pain, loss of consciousness, shortness of breath and other ailments, I should immediately stop using or consuming the ChiroThin product and, if my symptoms do not resolve immediately, I should consult my physician or go to the hospital emergency room.

I hereby consent to, and assume the risks associated with, the use and consumption of ChiroThin product and agree to follow the recommendations and instructions of my physician. I further agree not to use or consume any ChiroThin product without the advice, counsel, and recommendations of my physician.

I understand that Neuroemotional Technique (NET) is one of the techniques that may be used during my care. NET does not make claims as to what may have happened in the past. All memory events are considered “emotional reality” because events may or may not correspond with actual or historical reality.

I hereby release, discharge and agree to indemnify my physician, John Schellenberg, D.C., ChiroNutraceutical, their agents, servants employees and affiliates from any and all liability, claims, causes of action and demands for personal or bodily injury or death that I or my personal representatives might have or might hereafter acquire through my use or consumption of ChiroThin products.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

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INFORMED CONSENT TO CHIROPRACTIC CARE

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable. Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being. Neuroemotional technique (NET) is one of the techniques that may be used in the course of my care. NET does not make claims as to what may have happened in the past. All memory events are considered "emotional reality" because events may or may not correspond with actual or historical reality. It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users. It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit. I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____