

**Dr. Shawn Richey**  
**Chiropractic Family Health Center**  
**ChiroTHIN Doctor Supervised Weight Loss Program**  
**2591 Wexford Bayne Road, Suite 207 Sewickley, PA 15143 724-940-9000**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ Ok to send email? Yes No

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

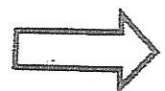
How did you find out about our weight loss program? \_\_\_\_\_

Are you currently pregnant? Yes No (If yes, you are not eligible to participate in this program)

Do you experience any of the following conditions even if they are minor and go away on their own? (Please check all that apply)

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Hypoglycemia    |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Neck Pain          | <input type="checkbox"/> Upper Back Pain      | <input type="checkbox"/> Numbness        |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Fibromyalgia        | <input type="checkbox"/> Numbness           | <input type="checkbox"/> Stress/Irritability  | <input type="checkbox"/> Sinus/Allergy   |
| <input type="checkbox"/> Hip/Knee Pain       | <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> Chronic Inflammation | <input type="checkbox"/> Other           |

1. Are you currently on any medications and for what health condition?  
\_\_\_\_\_
2. Why do you currently want to lose weight? \_\_\_\_\_
3. How long have you struggled with your weight? \_\_\_\_\_
4. Have you tried other weight loss plans and if so, what have you tried?  
\_\_\_\_\_
5. What were your results? \_\_\_\_\_
6. How long did you keep the weight off? \_\_\_\_\_
7. Do you currently take nutritional supplementation? Yes/No (if "yes" are you taking EFA's?  
You will need to discontinue EFA's while on this program)



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

I certify that the above information is true and correct to the best of my knowledge.

Sign

Date

Office Notes:



Disclaimer:

*ChiroHCG weight loss program makes no claims or warranties regarding outcomes of the HCG diet protocols. The results stated are based off of clinical observations of hundreds of HCG clients. Future clients are encouraged to search for themselves all information regarding the HCG diet protocols and to discuss their health concerns with their doctor before beginning any weight loss or diet programs.*