HAMMOND CHIROPRACTIC LIFE CENTER | 5716 Hohman Avenue | Hammond, IN 46320 | 219.932.8900 | Fax: 219.932.8944 | www.drdaulton.com |

Weight Loss Profile

Dietary consultation involves a health profile which aims to determine your health status rather than provide a diagnosis. This health status will help to guide your weight loss plan. You may be advised to seek medical advice based on your health profile.

General

Date: _____

Last name: _____ First name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Cell Phone Number: _____

Email: _____ Date of birth: _____

Circle one: Male Female

Health care provider: _____

How did you hear about us? _____

Referred by: _____

Current weight: _____ Goal weight: _____ Height: _____

Minimum adult weight: _____ at age: _____

Maximum adult weight: _____ at age: _____

Do you exercise? _____ What kind? _____

How often? _____

In the last 6 months have you had any stiffness, pain, or arthritic problems? Yes No

If yes, where? (Circle all that apply) Neck Mid back Low back Hips Knees Foot/ankle

Shoulders Arm Hand/wrist

Adrenal Fatigue Test

Check all boxes that apply to you.

Add up the total and place in the box below.

- ☐ I am frequently tired.
- ☐ I feel tired even after 8 to 10 hours of sleep.
- ☐ I am chronically stressed.
- ☐ It is difficult for me to handle stress.
- ☐ I am a night-shift worker.
- ☐ I work long hours.
- ☐ I have little relaxation time during my days.
- ☐ I get headaches frequently.
- ☐ I don't exercise consistently.
- ☐ I am or have been an endurance athlete (or participate in CrossFit).
- ☐ I have erratic sleep patterns.
- ☐ I wake up in the middle of the night.
- ☐ I crave salt.
- ☐ I have high sugar intake.
- ☐ I have difficulty concentrating.
- ☐ I carry weight in my midsection (an apple-shape body).
- ☐ I have low blood sugar issues (hypoglycemia).
- ☐ I have irregular periods.
- ☐ I have a low libido.
- ☐ I have PMS or perimenopausal/menopausal symptoms.
- ☐ I get sick frequently.
- ☐ I have low blood pressure.
- ☐ I have muscle fatigue or weakness.
- ☐ I rely on caffeine for energy (coffee, energy shots, etc.).

Total: ☐

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Treatment Consent Form

This consent to treatment form explains the risks and benefits of the Contour Light treatments. Patient understands the following:

1. Results vary greatly from person to person. No result is guaranteed.

2. Contour Light is a treatment intended to be implemented in conjunction with a modification in diet and lifestyle as part of a complete protocol. The recommended diet and lifestyle is a critical part of the program and are essential in achieving the maximum results.

3. Temporary hyper pigmentation/hypo pigmentation (changes in skin color) on rare occasion may occur as a result of treatment.

4. Contour Light should not be used by patients with any of the conditions listed below.

Conditions that Prevent Treatment

Patient agrees (by initialing) that all of the following are true:

_____ I am over the age of 18

_____ I do not have and never had any of the following medical conditions:

- Cancer (active or within 1 Year of remission)

- HIV/AIDS

- Hepatitis C or D

- Uncontrolled High Blood Pressure

_____ I am not pregnant or breastfeeding

_____ I do not have a pacemaker

SIGNATURE

By signing below, patient agrees that provider listed above may perform the Contour Light procedure for the purpose of body contouring.

Patient understands and accepts the risks listed above and agrees that all information provided on this form is true and correct to the best of patient's knowledge.

Patient Signature _____ Date _____

Printed Name _____

DISCLOSURE TO THIRD PARTIES (OPTIONAL)

By signing below, patient agrees to permit provider and third parties authorized by provider to use patient's name, photos and/or videos in the marketing of the Contour Light system and procedure. Absent a signature, provider will not disclose patient's identity to any third party except as required by law.

Patient Signature _____ Date _____

Printed Name _____

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Please be advised of the following guidelines for your Contour Light session:

- Do not eat 2 hours before and 2 hours after treatment. (This helps the liver focus on the fat that is stored in the body, not fat that was just consumed.)
- Drink 2 glasses of water before the treatment. (Hydrated fat cells will open and release more easily.)
- Reduce or eliminate alcohol consumption.
- Do not apply any lotions or creams to the body before treatment. Please wear no makeup or be prepared to remove it before treatment.
- Bring sports bra and loose fitting shorts (or a 2 piece bathing suit) for women. Bring underwear and loose fitting shorts for men. Please keep in mind that, wherever you want to lose inches, the light has to be emitting directly onto the skin in that area.
- 24 hour notice is required to cancel a Contour Light session. Any patient who misses a scheduled appointment and does not give ***at least 24 hours notice*** prior to the scheduled visit will be charged the fee of the session they were scheduled for.
- If other people accompany you on your Contour Light visit, they **must** be in the main floor reception room – **NO WANDERING AROUND**.
- Professional behavior is expected to be maintained at all times during your Contour Light session. We will discontinue your sessions in our office if you behave inappropriately.
- We ask our Contour Light patients to arrive at least 5 minutes early for their session (15 minutes early for the first session). If you arrive late for your session, you will lose that time and only receive treatment for the remainder of your scheduled time.

_____ _____

Signature Date

Patient Quality Of Life Survey Example

blueprint to Gut Health

PRACTICE INFORMATION HERE

Patient Quality Of Life Survey

Name: _____ ***Date:*** _____

Please take several minutes to answer these questions so we can help you get better.
(Please circle as many that apply)

1. How have you taken care of your health in the past?
   - **a.** Medications
   - **b.** Emergency Room
   - **c.** Routine Medical
   - **d.** Exercise
   - **e.** Nutrition/Diet
   - **f.** Holistic Care
   - **g.** Vitamins
   - **h.** Chiropractic
   - **i.** Other (please specify): _____

2. How did the previous method(s) work out for you?
   - **a.** Bad results
   - **b.** Some results
   - **c.** Great results
   - **d.** Nothing changed
   - **e.** Did not get worse
   - **f.** Did not work very long
   - **g.** Still trying
   - **h.** Confused

3. How have others been affected by your health condition?
   - **a.** No one is affected
   - **b.** Haven't noticed any problem
   - **c.** They tell me to do something
   - **d.** People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?
   - **a.** Job
   - **b.** Kids
   - **c.** Future ability
   - **d.** Marriage
   - **e.** Self-esteem
   - **f.** Sleep
   - **g.** Time
   - **h.** Finances
   - **i.** Freedom

5 Are there health conditions you are afraid this might turn into?

a. Family health problems
b. Heart disease
c. Cancer
d. Diabetes
e. Arthritis
f. Fibromyalgia
g. Depression
h. Chronic Fatigue
i. Need surgery

How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:

What are you most concerned with regarding your problem?

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific

What would be different/better without this problem? Please be specific

What do you desire most to get from working with us?

What would that mean to you?

Trust Your Gut Wellness Evaluation

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to LGS go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please take the quiz to help our doctors evaluate how we can help your condition and any underlying triggering limiting your health in process

Let's get started.

Please circle any that apply to you prior to taking the quiz below:

Sub-Clinical symptoms including:
Headaches and migraines

Hormone imbalance including:
PMS
Emotional imbalance

Gastrointestinal issues including:
Abdominal bloating and cramps or painful gas
Irritable Bowel Syndrome
Ulcerative Colitis
Crohn's Disease and other intestinal disorders

Respiratory Conditions including:
Chronic sinusitis
Asthma
Allergies

Autoimmune Conditions including:
Diabetes Mellitus
Lupus
Rheumatoid Arthritis
Fibromyalgia
Chronic Fatigue

Developmental and social concerns including:
Austism
ADD/ADHD

Skin Conditions: (urticaria)
Eczema
Skin rashes
Hives

Please complete our TYG wellness quiz. While there's more to it than a single quiz, the answers below can give you a good idea of how happy your gut really is. Circle the number that most closely fits, then add up your results.

TYG Wellness Questionnaire

	None	Mild	Moderate	Severe
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3

	None	Mild	Moderate	Severe
Asthma, hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Ulcerative colitis or celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight Trouble	0	1	2	3

YOUR TOTAL: _____