Shoreline Family Chiropractic & Wellness
Dr. Matthew Paterna ☺ Dr. Peter Braglia

The Accelerated Weight Loss Cleanse Program

Personal Analysis Form

Name _____ Phone _____

Address_____ Alt Phone _____

_____Email _____

DOB _____ Occupation _____

How did you hear about our office? _____

My ***CURRENT*** Height _____ feet _____ inches Weight _____ pounds

My ***IDEAL*** body weight is _____ pounds, and my time-frame goal of achieving this weight is _____

I am able to visualize myself healthy and at my ideal weight __yes __no

1. What is your primary health and wellness focus?

   _____ Energy /Endurance Development _____ Pain /symptom relief

   _____ Lean Mass Development /Toning _____ Toxic Fat Reduction / Wt. Loss

2. My Goal during the Cleanse Program is to reach my target weight of _____ pounds.
3. My other goals with considering a Cleanse are _____
4. Do you have any other lifestyle resolutions / goals you would like start doing?
   _____
5. If you currently exercise now, how frequently and what type of workout?
   _____
6. On a Scale of 1 to 10 (10-highest), how would you rate your level of commitment to achieving your health and wellness goals? _____
7. How long have you desired to lose weight and/or improve the quality of your overall health? _____
8. Accumulated Toxic Considerations: How often do you consume the following:

   Fast food _____ Soda / soft drinks _____
   Coffee _____ Tobacco / cigarettes _____
   Alcohol _____ Sugar products _____

9. My Stress mainly comes from _____

16 Ocean Avenue, West Haven, CT 06516
203-932-4476

10. ***Health History***

Please describe any / all conditions or diseases you have been diagnosed with by a doctor

_____

_____

Currently I suffer from: Headaches_____ Neck pain _____ Back pain _____

Digestive problems _____ Low energy _____ Sinus/Allergies_____

Fibromyalgia _____ Sleep Issues_____ Other symptoms: _____

Please list all medications you are currently taking _____

_____

Is there anything else the Doctor should know about your health, previous or current?

_____

11. Personal Health Analysis: Rate yourself from 1 to 10 in the following areas.
(1= Very poor and 10 = Ideal Health)

SCORE	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Physical Health										
Body Weight										
Energy Level										
Pain Level										
Relationship Health										
Emotional Health										

12. Based on thousands of people who have gone through this Cleanse program, those who created and used a support team achieved significantly better long-term results. It is recommended that your support team be people who are positive minded, care about you, and those who will support you in achieving long-term health & wellness.

My support team will include: _____

_____

13. I have tried to lose weight before by trying:_____

14.At the end of my Cleanse program, I wish to be:

_____

15. I understand that my insurance company will not cover the cost of the products, however they may offer coverage for the nutritional consultation.

Signature_____ Date_____

Name of Your Insurance Company_____ Policy #_____