ORTHORITY 360™
TOTAL BODY WELLNESS

WEIGHT LOSS INTAKE FORM
TREATMENT RECORD

TODAY'S DATE

FIRST NAME		LAST NAME	
DATE OF BIRTH	HEIGHT	CURRENT WEIGHT	DESIRED WEIGHT

MEDICAL HISTORY

◯ HIGH BLOOD PRESSURE ◯ DIABETES ◯ OTHER (LIST IN SPACE BELOW) ◯ HIGH CHOLESTEROL ◯ THYROID DISORDER	
PLEASE LIST ANY PAST SURGERIES/APPROXIMATE DATE	
ARE YOU SEEING A PRIMARY CARE PROVIDER/SPECIALIST? ◯ YES ◯ NO	IF "YES", LIST NAME AND SPECIALTY
CURRENT MEDICATIONS AND DOSE	
ALLERGIES	
ANY PERSONAL/FAMILY HISTORY OF THYROID CANCER? ◯ YES ◯ NO ◯ NOT SURE	IF "YES", PLEASE EXPLAIN
HAVE YOU TRIED OTHER WEIGHT-LOSS PROGRAMS? ◯ YES ◯ NO	IF "YES", WHICH ONES?
HOW MANY OUNCES OF WATER DO YOU DRINK DAILY?	DO YOU CONSUME SOFT DRINKS? ◯ YES ◯ NO
DESCRIBE YOUR SLEEP HABITS	
DESCRIBE YOUR ENERGY LEVEL	
HOW OFTEN DO YOU WORK OUT? ◯ NEVER ◯ 1-2 TIMES PER WEEK ◯ 3-4 TIMES PER WEEK ◯ 5+ TIMES PER WEEK	
DESCRIBE YOUR CURRENT WORKOUT ROUTINE	
GOALS/UPCOMING EVENTS	
PATIENT IS CLEARED FOR WEIGHT-LOSS PROGRAM? ◯ YES ◯ NO	RECOMMENDED WEIGHT-LOSS PROGRAM