**Date___/____/_____**

File Number_____

SHAPE ReClained Intake Form

**Thank you for choosing Crossroads Family Chiropractic for your current health concerns and your wellness needs! Dr. Keen is honored to be your coach in getting you and your family on a path to a healthier lifestyle. Please fill out the following form as thoroughly as possible.**

**PERSONAL INFORMATION**

Patient Name _____ Female  Male 

Date of Birth____/___/_____ Age_____

Home Address _____City_____ State___ Zip_____

Home Phone (____)____-_____ Cell (____)____-_____ Email _____

Occupation _____ Employer _____

Employer Address _____ Employer Phone (____)_____-_____

Spouse/Partner Name _____ Spouse/Partner Phone (___)____-_____

*Who may we thank for referring you to the office?* _____

**RELEASE**

I, the undersigned, authorize the Dr. and her staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a photo static copy of this agreement shall serve as the original.

X_____

Patient Signature Date

_____

# SHAPE ReClaimed Questionnaire

| OFFICE USE ONLY |
|---|
| DATE: |
| [ ] HA TODAY<br>[ ] HA PHASE II<br>[ ] CURRENT HA NC |

**Patient:_____Age:_____**

**M / F: Menstruating/ Menopausal/ Pregnant**

| Medication(s) List | Do you want to get<br>Off this medication ? | OFFICE USE USE ONLY<br>Date/Amt of Reduction | <br>Or Eliminati on |
|---|---|---|---|
| | YES<br>NO | | |
| | YES<br>NO | | |
| | YES<br>NO | | |
| | YES<br>NO | | |
| | YES<br>NO | | |
| | YES<br>NO | | |

**Have you been formally diagnosed by a physician with Diabetes or Insulin Resistance? YES**

**NO**

**Do you have a history of any of the following? Circle those that apply.**

| | | | |
|---|---|---|---|
| Gall Ston es | Gall Bladder Attacks | Gall Bladder Surgery | Skin issues: psoriasis, eczema, rashes, fungus |
| Heada ch es | Constipation | Belching/ Indigesti on | Pain in shoulders, hips, side of body |
| Ange n | Knee Issues | Ear/Eyes Issues | Muscle tightness, cramping, spasms |

**Are you currently undergoing any of the following cancer treatments?**

| | | |
|---|---|---|
| Chemotherapy | Radiati on | Trial Drugs |

**Main reason(s) for doing SHAPE ReClaimed?**

**1.**_____

**2.**_____

**3.**_____

**What things can't you do due to Pain/Inflammation/ Weight that you wish you could?**

**1.**_____

**2.**_____

**3.**_____

**If you are doing Shape ReClaimed for weight loss, what are your short & long term goals?**

| | |
|---|---|
| | **LONG TERM:** |

# Food Habits

Do you mostly cook at home or do you mostly eat out? COOK AT HOME EAT OUT
Are you comfortable cooking in the kitchen? YES NO
Do you rely on recipes for cooking or do you get creative? RECIPES CREATIVE
Are you an emotional eater? YES NO
If yes, what emotion causes you to eat: ANGER SADNESS HAPPINESS GRIEF ANXIETY DEPRESSION OTHER
Do you eat out of boredom? YES NO
What food is your favorite / your weakness? _____

**INFORMED CONSENT**: I understand that if I am on any medications, I have been advised to consult my prescribing physician in regards to the dosage reduction and/or elimination of my medication(s) as my physiology changes while on the Shape ReClaimed program. I also agree to remain compliant with the guidelines of the program. If I stray from the requirements & recommendations outlined, I understand that results are not guaranteed and that continued purchase of Shape ReClaimed drops will not be allowed per Dr. Frye and Shape ReClaimed.

**Signature:**_____

_____

**Date**