

**Brought to you by:**

**Freeport Family Chiropractic & Acupuncture**

[**www.freeportfamilychiro.com**](http://www.freeportfamilychiro.com) **815-232-4217**

**SHAPE ReClaimed Intake Form**

How did you hear about the SHAPE ReClaimed program? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why and what health benefits do you want to achieve with the SHAPE ReClaimed program?

 (You **MUST** have a non-weight related reason!)

□ Improved eating habits □ Improved well-being □ Decreased inflammation □ Weight reduction

□ Increased energy □ Improved sleep □ Increased stamina □ Body Detox and Cleanse

What other goals are you seeking with this program? (i.e. managing/maintaining a health condition) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Physical Health***

Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On average, how many hours do you sleep per night? □ <5 □ 6 □ 7 □ 8 □ 9 □ 10

Do you wake up feeling refreshed? □ Always □ Sometimes □ Rarely □ Never

Have you ever been hospitalized or had surgery? □ No □ Yes If yes, why and when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been diagnosed with any clinical condition or disease? □ No □ Yes If yes, what: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had blood work performed in the last year? □ No □ Yes

Were your test results in medically normal ranges? □ No □ Yes If not, which results were abnormal?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Chemical Health***

Have you used antibiotics in the last year? □ No □ Yes

How many cups of water do you drink per day? □ 0 □ 1-3 □ 4-6 □ 7-9 □ 10+

How many cups of coffee/energy drinks do you drink per day? □ 0 □ 1-3 □ 4-6 □ 7-9 □ 10+

How many glasses of juice/soda/sports drinks do you drink per day? □ 0 □ 1-3 □ 4-6 □ 7-9 □ 10+

Do you eat wheat products (bread/pasta/crackers/baked goods)? □ No □ Yes If yes, how many servings per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you eat refined sugar? □ No □ Yes If yes, how many servings per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What foods do you crave? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you ingest artificial sweeteners (Splenda, Aspartame, Equal, diet drinks, gum)? □ No □ Yes

Do you have any food/drink allergies, sensitivities or intolerances? □ No □ Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? □ No □ Yes □ I used it for: \_\_\_\_\_\_\_ years

Are you/have you been exposed to second-hand smoke? □ No □ Yes

Do you take probiotics? □ No □ Yes

Do you take Vitamin D? □ No □ Yes

Do you take Omega-3? □ No □ Yes

Other supplements or homeopathics: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medications that you take regularly and why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , hereby grant permission to receive a***

***professional and complete physical examination and consultation, including urinalysis and evaluation.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

**SHAPE ReClaimed Informed Consent & Acceptance of Responsibility**

**Patient Informed Consent**

I, \_\_\_\_\_ \_\_\_\_\_, understand that SHAPE ReClaimed is a lifestyle modification, health restoration program designed to help me improve my overall health. This program is not intended to replace the guidance of my primary health care experts. While this program is not used to diagnose, treat, cure or prevent any disease, I understand any medications I am currently taking may need dose adjustment. I agree to notify my prescribing physician that I am working with \_Dr. Roger Sdao\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ and will be closely monitored while incorporating this program for embracing a healthier lifestyle. I understand an anti-inflammatory nutritional regimen will be recommended based on my unique health history, urinalysis and symptoms.

**Doctor/Office/Clinic Statement of Intent**

We, Freeport Family Chiropractic & Acupuncture \_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand that our intent and responsibility is to determine if SHAPE ReClaimed is a program that would be beneficial for assisting your body in its innate healing process. Our first appointment with you will be multi-faceted. We agree to do the following:

* Take full health history
* Assess
* Discuss health goals
* Perform baseline urinalysis
* Make specific recommendations (nutrition, supplements, diagnostics)
* Determine follow-up protocol
* Educate regarding living a healthy lifestyle

**Patient Acceptance of Responsibility**

I have been informed and understand that nutritional and lifestyle recommendations may involve certain risks. These may include, but are not limited to, detoxification symptoms, such as: initially feeling worse due to the release of stored toxins, digestive symptoms, fatigue, headaches, muscle and joint pain, allergic reactions or any unpredictable reaction with my prescribed medications that has not been found in research literature.

In addition, I agree to do the following:

* Submit full health history
* Discuss health goals
* Have consistent urinalysis and follow-up visits as recommended by SHAPE practitioner
* Read *The Complete Patient Guidebook*
* Review the information provided under the “Patient Education” tab on www.shapereclaimed.com
* Be aware that I can join the “OFFICIAL SHAPE ReClaimed Support Group” on Facebook and will not substitute recommendations from Facebook for my specific health needs
* Understand that my SHAPE Practitioner can refuse sale of additional product if I have not followed the recommended protocol set up for my healing

**I have read or have had read to me the above information. I have had the opportunity to ask questions about its contents and by signing below, I agree to these conditions for the duration of my SHAPE ReClaimed journey. I am responsible for all fees incurred and agree to pay, in full, for any service provided the day service is rendered.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Patient Name (Print) Patient Signature

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Date Signed