Office Use Only
Date:________________
[ ] HA TODAY
[ ] HA PHASE II

Shape ReClaimed Questionnaire

Patient:___________________________DOB:__________________Age:__________ M / F

Female Patients ONLY: Menstruating / Menopausal / Pregnant

Medication(s) List	**Do you want to get off this medication?**	**Office Use Only**	
		Date/Amt of Reduction	**Or Elimination**
	Yes No		
	Yes No		
	Yes No		
	Yes No		
	Yes No		
	Yes No		

Have you been formally diagnosed by a physician with Diabetes of Insulin Resistance?

YES NO

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

Gall Stones	Gall Bladder Attacks	Gall Bladder Surgery	Skin issues: psoriasis, exzema, rashes, fungus
Headaches	Constipation	Belching/ Indigestion	Pain in shoulder, hips, side of body
Anger	Knee Issues	Ear/ Eyes Issues	Muscle tightness, cramping, spasms

Are you currently undergoing any of the following cancer treatments?

Chemotherapy	Radiation	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?

Short Term:	**Long Term:**

Food Habits

D you mostly cook at home or do you mostly eat out? COOK AT HOME EAT OUT

Are you comforable cooking in the kitchen? YES NO

Do you rely on reciepes 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 medication, 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 whiles 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 the results are no guaranteed and that continued purchase of Shape ReClaimed drops will not be allowed per Dr. Jill Reavis-Aleman, L.Ac., DOM and Shape ReClaimed.

Signature:____**Date:**________________