DOCTOR SUPERVISED CHIROTHIN WEIGHT LOSS PROGRAM & Vevazz.com offered at One Light™ Weight Loss Center

Weight Loss Intake Form

Name _____ D.O.B. _____/_____/_____ Age _____ Sex ◯M ◯F

Address _____City/State/Zip _____

Best Phone _____ ☐ Cell? Email_____

Status ◯M ◯S ◯D ◯W Number of Children _____ Do you currently see a chiropractor? ◯N ◯Y _____

Occupation _____ Referred By _____

What are your motivations for wanting to lose weight and inches?

What is your current weight? _____lbs and current pant/dress size? _____ Height _____ft _____in_____

I would like to lose approximately _____ lbs and my goal weight would be _____ lbs

I would like to lose approximately _____ pant or dress sizes and my goal would be size _____

I would like to reduce my ☐ tummy ☐ arms ☐ legs ☐ buttocks ☐ face/neck ☐ cellulite

If you have ever tried to lose weight before, please list what you have done and the results you achieved:

Think about your body in its current form and honestly answer how it is affecting your life in each of the following places:

Work/Productivity: ◯Increases ◯Decreases ◯Doesn't Effect Comments: _____

Energy Levels: ◯I'm Vibrant ◯I'm Tired ◯I'm Exhausted ◯Doesn't Effect Comments: _____

Sleep: ◯More Rested ◯Less Rested ◯Doesn't Effect Comments: _____

Mood: ◯I'm Happier ◯I'm More Irritable ◯Doesn't Effect Comments: _____

Hobbies/Sports: ◯Improves Performance & Enjoyment ◯Negatively Effects ◯N/A Comments: _____

Social Life: ◯Makes me More Social ◯I'd Rather Stay Home ◯Doesn't Effect Comments: _____

Intimacy: ◯Improves it ◯This is a Problem ◯Doesn't Effect Comments: _____

Family Life: ◯Enhances it ◯Negatively Effects ◯Doesn't Effect Comments: _____

Marriage: ◯Enhances it ◯Source of Strain in my marriage ◯Doesn't Effect Comments: _____

Continued on next page

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Please answer the following lifestyle questions:

How often do you consume alcohol? ○ Never ○ Rarely ○ Once a week ○ Daily ○ This is a real problem for me

Do you drink coffee? ○ Yes ○ No How much? _____

Do you drink regular soda pop? ○ Yes ○ No How much? _____

Do you drink diet soda pop? ○ Yes ○ No How much? _____

Do you overeat? ○ Never ○ Rarely ○ Once a week ○ Daily ○ This is a real problem for me

Do you crave/eat sugar & carbohydrates ○ Yes ○ No ○ This is a problem for me

Do you exercise? ○ Yes ○ No How often and what? _____

What time do you normally first put some type of food in your mouth? _____

What time do you normally finish eating/snacking before going to bed at night? _____

Do you experience chronic pain? ○ Yes ○ No

Do you have any autoimmune disorders? ○ Yes ○ No _____

Do you smoke? ○ Yes ○ No Are you often exposed to chemicals? ○ Yes ○ No _____

How much purified water do you drink per day? ○ little to none ○ with meals ○ at least half my body weight in oz

Regarding sleep: ○ I get enough sleep and feel rested upon waking ○ I have difficulty falling asleep
○ I wake up and can't get back to sleep ○ I have broken sleep ○ I have difficulty getting up and moving in the morning

On a scale from 0-10 with 0 being none & 10 being extremely high, I would grade my overall stress level as: _____

My two greatest stressors are: _____ and _____

Please use this area to describe any significant emotional trauma, injuries/accidents and approximate age they occurred:

1. _____ age: _____ 4. _____ age: _____
2. _____ age: _____ 5. _____ age: _____
3. _____ age: _____ 6. _____ age: _____

Other:

Please check Yes or No to the following questions:

Do you have a pacemaker?	○ Yes ○ No	Do you have epilepsy?	○ Yes ○ No
Have you ever had your thyroid radiated/removed?	○ Yes ○ No	Do you have active cancer?	○ Yes ○ No
Do you have any known photosensitivity?	○ Yes ○ No	Do you have active gall bladder disease?	○ Yes ○ No
Do you have or have you ever had: A liver disorder?	○ Yes ○ No	A kidney disorder?	○ Yes ○ No
(Females Only) Are you pregnant?	○ Yes ○ No	Are you breast feeding?	○ Yes ○ No

Continued on next page

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Do you experience any of the following conditions even if they are minor and go away on their own?

☐ High Blood Pressure	☐ Diabetes	☐ Headaches	☐ Hypoglycemia
☐ Cancer	☐ Neck Pain	☐ Upper/Low Back Pain	☐ Thyroid Problems
☐ Heart Disease	☐ Digestive Problems	☐ Arthritis	☐ Chronic Fatigue
☐ Fibromyalgia	☐ Numbness	☐ Stress/Irritability	☐ Sinus/Allergy
☐ Hip/Knee Pain	☐ Osteoporosis	☐ Chronic Inflammation	☐ Other

Family History – Please indicate any of your relatives who have had any of the following conditions:

☐ Alcoholism _____	☐ Anemia _____	☐ Arthritis _____	☐ Cancer _____	☐ Diabetes _____
☐ Emphysema _____	☐ Epilepsy _____	☐ Glaucoma _____	☐ High BP _____	☐ Stroke _____
☐ Heart Disease _____	☐ Osteoporosis _____	☐ Mental Illness _____	☐ Other _____	

Please list any medications you are taking & what they are treating.

1. _____
2. _____
3. _____

Please list any vitamins and natural supplements you are taking.

_____ _____

_____ _____

_____ _____

Do you have any other health issues you feel are important for us to know about?

Local Client (within 90 miles of Fargo, ND) Services:

☐ I am interested in learning about ChiroThin and Vevazz for the fastest and most dramatic weight loss results

I am only interested in: ☐ ChiroThin Doctor Supervised Weight Loss Program
☐ Vevazz Laser Like Lipo System

☐ I am interested in the Integrated Urinalysis Panel to discover how my body is breaking down and what supplementation I need to be taking to improve my weight loss results and my overall health.

☐ I would be interested in receiving a free chiropractic evaluation.

Non-Local Client Services:

I am interested in:

☐ ChiroThin Doctor Supervised Weight Loss Program

☐ I am interested in the Integrated Urinalysis Panel to discover how my body is breaking down and what supplementation I need to be taking to improve my weight loss results and my overall health.

Continued on next page

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INFORMED CONSENT AND RELEASE OF LIABILITY

I understand that my use and consumption of any ChiroThin product or engaging in any weight loss program including the type that is to be used in conjunction with ChiroThin, have inherent risks to my health and well-being, including but not limited to headaches, nausea, dizziness, vomiting, fatigue, pain, loss of consciousness, shortness of breath and other ailments. I understand as well that rapid weight loss of over 1-2 lbs. per week is considered by most in the weight loss medical community to be excessive and may lead to ailments similar and in addition to those mentioned above. Therefore, I understand that my failure to follow the weight loss program exactly as described to me by One Light Weight Loss Team members can result in severe temporary and/or permanent medical conditions in addition to those mentioned above.

I understand that I am not to use or consume any of the ChiroThin products or participate in the Vevazz Body Contouring system if I am pregnant or think I might be pregnant, if I have active cancer or active gall bladder disease. I understand I am not to receive Vevazz Body Contouring sessions if I have a pacemaker, open sores over treatment areas, have active or past kidney or liver disease, have had my thyroid gland radiated or removed, have epilepsy, have photosensitivity to sunlight or take drugs that can make me photosensitive to light.

I understand that, as a dietary supplement, ChiroThin has not been approved by the FDA or any Federal or State authority. I additionally understand that The ChiroThin Weight Loss Program is not meant to diagnose, treat or cure any disease or medical condition and that I am to undergo participation in the ChiroThin Weight Loss Program only under doctor supervision. I also understand that I should consult with my doctor prior to starting ANY exercise or nutritional supplement program.

I understand that, if I experience any ailment, including but not limited to headaches, nausea, dizziness, vomiting, fatigue, pain, loss of consciousness, shortness of breath and other ailments, I should immediately stop using or consuming the ChiroThin product and, if my symptoms do not resolve immediately, I should consult my physician or go to the hospital emergency room.

I hereby consent to, and assume the risks associated with, the use and consumption of ChiroThin product and agree to follow the recommendations and instructions of my physician. I further agree not to use or consume any ChiroThin product without the advice, counsel, and recommendations of the One Light Weight Loss Center Team.

Vevazz is a treatment intended to work in conjunction with changes in diet and lifestyle recommended as part of the One Light Weight Loss System. The recommended diet and lifestyle changes are a key part of the program and assist greatly in making the treatments effective. Temporary hyperpigmentation / hypopigmentation (changes in skin color) on rare occasion may occur as a result of Vevazz treatments. I understand that, if I am signing for a minor, they must be 12 years of age to participate in ChiroThin program. I understand that I must be at least 18 years of age to receive Vevazz treatments.

I understand that Neuroemotional Technique (NET) is one of the techniques that may be used during my care. NET does not make claims as to what may have happened in the past. All memory events are considered “emotional reality” because events may or may not correspond with actual or historical reality.

I hereby release, discharge and agree to indemnify One Light Weight Loss, John Schellenberg, D.C., ChiroNutraceutical, Vevazz, their agents, servants, employees and affiliates from any and all liability, claims, causes of action and demands for personal or bodily injury or death that I or my personal representatives might have or might hereafter acquire through my use or consumption of ChiroThin products, Vevazz treatments or nutritional and homeopathic support and detox products used in my program.

I understand that results vary greatly from person to person and that I must follow the recommendations to obtain maximal results. I understand that no result is guaranteed, no refunds are given and any unused sessions will remain available for future use.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____