Cenk Integrated Health & Spine Centers
107 Gamma Drive, Suite 100
Pittsburgh, PA 15238
412.967.9767

Skinny Light Health Information

Name: ______________________________ Date: ____________________

Address: ____

City: ____________________ State: ______________ Zip Code: ________________

Cell Phone: ____________________________ Home Phone: _______________

Email Address: ____

Treatment Goals

Current Weight: ____________________ Current Age: __________________

Do you want to lose _____ inches _____ weight _____ both _____ other ____________

How much weight do you want to lose? ___________________

Are you interested in learning about our Metabolic Weight Loss Program? Yes or No

How committed are you to making a permanent change to your life and health?

1 2 3 4 5 6 7 8 9 10

How did you hear about us? ____

Do you currently have or have had any of the following in the past?

(Please check all that apply)

[ ] fatigue
[ ] over heating
[ ] mental fatigue
[ ] acid reflex
[ ] constipation
[ ] high cholesterol
[ ] take pain medication
[ ] difficulty falling asleep

[ ] low sex drive
[ ] cold hands & feet
[ ] depression
[ ] diarrhea
[ ] gas after a meal
[ ] diabetes
[ ] inflammation
[ ]difficulty staying asleep

[ ] sugar cravings
[ ] menopause
[ ] abdominal pain
[ ] high amounts of stress
[ ] fatigue after meals
[ ] high blood pressure
[ ] irritable if meals are missed

Cenk Integrated Health & Spine Centers
107 Gamma Drive, Suite 100
Pittsburgh, PA 15238
412.967.9767

Have you been diagnosed with/suffer with/ or are you taking medications for any of the following? *(Please check all that apply)*

[ ] type II diabetes
[ ] knee pain
[ ] headaches
[ ] shoulder pain
[ ] albinism
[ ] tingling/numbness
[ ] pregnant/trying
[ ] cancer __________
[ ] back pain
[ ] hip pain
[ ] kidney problems
[ ] Dr. said to avoid light
[ ] hyperthyroid
[ ] autoimmune disease
[ ]muscle pain
[ ] hysterectomy
[ ] peripheral neuropathy
[ ] lupus
[ ] fibromyalgia
[ ] disc bulge/herniation
[ ] hypothyroid
[ ] lactose intolerant
[ ] joint pain
[ ] hormone replacement therapy

Please list any other medical issues not listed above:

____

____

Who is your primary care doctor?

____

What is your motivation to lose weight?

____

____

I understand that:

- *The consultation/exam is preliminary in nature; your answers are used to screen for medical issues that would not allow you to receive treatment, they are not used to render a medical diagnosis.*
- *It is my responsibility to disclose every medical issue that I am suffering from. I understand that by not disclosing all medical issues I may not achieve my desired weight loss results.*
- *I understand that results vary and that no guarantee has been made to me for success, in any way I may view it.*

Signature______________________________ **Date** ______________