

Dear Applicant,

Thank you for contacting my office regarding our weight loss program! I have had patients ask me for years about weight loss, but I didn't have anything special to tell them. Most of the popular approaches I had seen either did not work or were downright dangerous.

Two years ago, I had some colleagues recommend a homeopathic weight loss program that was safe, created amazing results, and led to long-term weight loss. I thought it was too good to be true so I ignored their recommendation. About six months ago, I was prodded again to look into this life-changing program. I researched it and found that the program has been around for a very long time. The results were real, the patients who had tried it were thrilled, and it was safe.

I began offering this program in my office and the results have been all that was promised. I love it, the patients love it, and the patients' family and friends love it!

To apply for the program, the first thing you will want to do is fill out and return the enclosed paperwork. This will give me an idea of what you have tried in the past, insight into why you may have had problems, and give you the opportunity to tell me everything you want me to know. Please take the time to fill these forms out thoroughly. One of the most important forms in this packet is the Metabolic Assessment Form. This form will help identify areas of dysfunction in your body and uncover problems that may hinder weight loss.

This program is for individuals who are serious about losing weight. I do not accept everyone who applies into the program. If the paperwork is filled out "half-heartedly" and appears thrown together with minimal effort, I will not review it, your application fee will be returned, and you will not be a candidate for this program. I value my time and my patients' time and refuse to squander time on an individual that simply does not care. I realized long ago that I can't care more about a patient's health than they do.

With that being said, my passion is the help people change their lives. Healthy weight loss does not just impact someone's physical health, but also their emotional health, spiritual health, social health, it raises self-esteem, and improves relationships. I think you would agree that those changes can make a massive difference in someone's quality of life and future.

If you would like to apply for the program, fill out the enclosed paperwork, mail (or drop off in person) your completed forms, enclose a check to cover the application fee or call and pay over the phone with a credit or debit card. (At this time, the application fee for the program is \$50, but will rise as the demand for this program continues to increase.) I will review your paperwork, develop some options on how we can proceed, and then you and I will sit down together and discuss which option you wish to pursue. I look forward to working with you.

Yours in Health,



Dr. Rick Montgomery

<i>All questions contained in this history form are strictly confidential and will become part of your medical record on file.</i>						Chart:
Last Name:	First Name:	Middle:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date: / /	Age:	Date:
Primary Physician/Referral:			Physician Phone Number: ()			Revisions:
Optometrist/Ophthalmologist:			Ophthalmologist Phone Number: ()			Weight:
Last Physical:		Last EKG:	Last Eye Exam:		Goal Weight:	

	Family	Personal		Family	Personal		Family	Personal
Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Pulse	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Bloody Stool	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	Moodiness	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>

Comments/Other:

Year	Reason / Diagnosis	Hospital

Medication Name	Reaction

	Chart:
<i>Product Name, Strength, Frequency of Use, Etc.</i>	

<input type="checkbox"/> You are always calm and easy going.	<input type="checkbox"/> You are usually calm and easy going.	<input type="checkbox"/> You are sometimes calm and easy going.
<input type="checkbox"/> You are seldom calm and persistently driving for advancement.	<input type="checkbox"/> You are never calm and have overwhelming ambition.	<input type="checkbox"/> You are hard-driving and never relax.

<input type="checkbox"/> Sedentary (no exercise)
<input type="checkbox"/> Mild Exercise (i.e., climbing stairs, walking three blocks, golf)
<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation less than 4 times per week for 30 minutes)
<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4 times per week or more for 30 minutes or more)

Are you dieting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If yes, are you on a physician-prescribed medical diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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How many meals do you eat in an average day?		
--	--	--

Rank your salt intake:	<input type="checkbox"/> High	<input type="checkbox"/> Medium	<input type="checkbox"/> Low
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Rank your fat intake:	<input type="checkbox"/> High	<input type="checkbox"/> Medium	<input type="checkbox"/> Low
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Rank your caffeine intake:	<input type="checkbox"/> High	<input type="checkbox"/> Medium	<input type="checkbox"/> Low	<input type="checkbox"/> None
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What types of caffeine do you drink?	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Soda
--------------------------------------	---------------------------------	------------------------------	-------------------------------

How many cups/cans per day?		
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Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If yes, what kind?	<input type="checkbox"/> Beer	<input type="checkbox"/> Liquor	<input type="checkbox"/> Wine
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How many drinks per week?		
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Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
---------------------	------------------------------	-----------------------------

<input type="checkbox"/> Cigarettes – packs/day:	<input type="checkbox"/> Chew – #/day:	<input type="checkbox"/> Pipe – #/day:	<input type="checkbox"/> Cigars – #/day:
--	--	--	--

How many years?		
-----------------	--	--

If you previously used tobacco, what year did you quit?		
---	--	--

Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
--	------------------------------	-----------------------------

Have you ever taken street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
---	------------------------------	-----------------------------

Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
--------------------------	------------------------------	-----------------------------

If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
---	------------------------------	-----------------------------

If you are not trying for a pregnancy, what contraceptive methods are you using?		
--	--	--

How old were you at onset of menstruation?	Date of last menstruation?	
--	----------------------------	--

How often do you get your period (days)?	Number of Pregnancies:	Number of live births:
--	------------------------	------------------------

Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
--	------------------------------	-----------------------------

Are you pregnant, trying for pregnancy, or breast feeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
--	------------------------------	-----------------------------

1. What is the main reason you decided to lose weight?
2. When did you begin gaining excess weight (give reasons if known)?
3. What do you think is the main cause of your weight problems?
4. Describe your previous attempts at weight loss or previous diets you have followed. Give dates and results if possible.
5. Is your spouse, fiancé, or partner overweight?
6. How often do you dine out? What restaurants do you frequent? What types of food do you eat there?
7. List any food allergies:
8. What foods do you avoid?
9. What foods do you crave?
10. Do you awaken hungry during the night?
11. What are your worst food habits?
12. What are your snack habits?
13. Rate your body from 1 to 10. How would you describe your body?
14. If you could change one thing about your body, what would it be?
15. What do you feel will be your obstacle(s) to successful weight loss?
16. What is your typical breakfast? What time? Where? With whom?
17. What is your typical lunch? What time? Where? With whom?
18. What is your typical dinner? What time? Where? With whom?
19. Add any additional comments you think would be helpful to the doctor.

I hereby agree that the information contained in this medical history is accurate to the best of my knowledge.

Signature:

Date:

Thank You.

This information will assist us in establishing your medical history and identifying problem areas. Thank you for your time and patience in completing this form.

Montgomery Chiropractic Wellness Center, LLC

Rick Montgomery, D.C.

3818 N. 1st Ave. Evansville, IN 47710

Phone (812) 424-7823 -- Fax (812) 424-7824

Name: _____

Date: _____

Please take several minutes to answer these questions so Dr. Montgomery can help you the most. **(Please check as many that apply)**

1. How have you approached weight loss in the past?

- | | |
|---|--|
| <input type="checkbox"/> Medications | <input type="checkbox"/> Diets; If so, How Many? _____ |
| <input type="checkbox"/> Exercise Products | <input type="checkbox"/> "Magic Cure" product |
| <input type="checkbox"/> Altered Nutrition (Eating "Right") | <input type="checkbox"/> Joining a Gym |
| <input type="checkbox"/> Vitamins/Supplements | <input type="checkbox"/> Gastric Bypass/Surgery |
| <input type="checkbox"/> Other(please specify): _____ | |
| <input type="checkbox"/> Other(please specify): _____ | |

2. How did the previous method(s) work out for you?

- | | |
|--|---|
| <input type="checkbox"/> Bad results (health declined afterward) | <input type="checkbox"/> Some results |
| <input type="checkbox"/> Great results | <input type="checkbox"/> Nothing changed |
| <input type="checkbox"/> Did not get worse | <input type="checkbox"/> Did not work very long |
| <input type="checkbox"/> Still trying | <input type="checkbox"/> Confused |

3. How have others been affected by your health condition?

- | | |
|--|--|
| <input type="checkbox"/> No one is affected | <input type="checkbox"/> Haven't noticed any problem |
| <input type="checkbox"/> They tell me to do something | <input type="checkbox"/> People avoid me |
| <input type="checkbox"/> I'm not as social as I would like | <input type="checkbox"/> Other _____ |

4. What are you afraid this might be (or beginning) to affect (or will affect)?

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Job | <input type="checkbox"/> Kids |
| <input type="checkbox"/> Future ability | <input type="checkbox"/> Marriage |
| <input type="checkbox"/> Self-esteem | <input type="checkbox"/> Sleep |
| <input type="checkbox"/> Time | <input type="checkbox"/> Finances |
| <input type="checkbox"/> Freedom | <input type="checkbox"/> Other _____ |

5. Are there health conditions you are afraid this might turn into?

- | | |
|---|--|
| <input type="checkbox"/> Family health problems | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Arthritis & Joint Pain | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Need surgery | <input type="checkbox"/> Impacting Children's Future |

Continued On Back

Please answer the following questions in detail. Feel free to use extra sheets of paper to elaborate on items you feel are important. This is your chance to tell Dr. Montgomery everything you want him to know.

How has your weight affected your job, relationships, finances, family, or other activities? Please give examples: _____

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples _____

What are you most concerned with regarding your weight? _____

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific _____

What would be different/better without this problem? Please be specific. _____

What do you desire most to get from working with us? _____

What is that worth to you? _____

Metabolic Assessment Form

Name: _____ Age: _____ Sex: _____ Date: _____

Please list the 5 major health concerns in your order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Please circle the appropriate number "0 - 3" on all questions below. 0 as the least/never to 3 as the most/always.

Category I			
Feeling that bowels do not empty completely	0	1	2 3
Lower abdominal pain relief by passing stool or gas .	0	1	2 3
Alternating constipation and diarrhea	0	1	2 3
Diarrhea	0	1	2 3
Constipation	0	1	2 3
Hard, dry, or small stool	0	1	2 3
Coated tongue of "fuzzy" debris on tongue	0	1	2 3
Pass large amount of foul smelling gas	0	1	2 3
More than 3 bowel movements daily	0	1	2 3
Use laxatives frequently	0	1	2 3
Category II			
Excessive belching, burping, or bloating	0	1	2 3
Gas immediately following a meal	0	1	2 3
Offensive breath	0	1	2 3
Difficult bowel movements	0	1	2 3
Sense of fullness during and after meals	0	1	2 3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0	1	2 3
Category III			
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2 3
Use antacids	0	1	2 3
Feel hungry an hour or two after eating	0	1	2 3
Heartburn when lying down or bending forward	0	1	2 3
Temporary relief from antacids, food, milk, carbonated beverages	0	1	2 3
Digestive problems subside with rest and relaxation .	0	1	2 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2 3
Category IV			
Roughage and fiber cause constipation	0	1	2 3
Indigestion and fullness lasts 2-4 hours after eating	0	1	2 3
Pain, tenderness, soreness on left side under rib cage	0	1	2 3
Excessive passage of gas	0	1	2 3
Nausea and/or vomiting	0	1	2 3
Stool undigested, foul smelling, mucous-like, greasy, or poorly formed	0	1	2 3
Frequent urination	0	1	2 3
Increased thirst and appetite	0	1	2 3
Difficulty losing weight	0	1	2 3

Category V			
Greasy or high-fat foods cause distress	0	1	2 3
Lower bowel gas and or bloating several hours after eating	0	1	2 3
Bitter metallic taste in mouth, especially in the morning	0	1	2 3
Unexplained itchy skin	0	1	2 3
Yellowish cast to eyes	0	1	2 3
Stool color alternates from clay colored to normal brown	0	1	2 3
Reddened skin, especially palms	0	1	2 3
Dry or flaky skin and/or hair	0	1	2 3
History of gallbladder attacks or stones	0	1	2 3
Have you had your gallbladder removed	Yes	No	
Category VI			
Crave sweets during the day	0	1	2 3
Irritable if meals are missed	0	1	2 3
Depend on coffee to keep yourself going or started .	0	1	2 3
Get lightheaded if meals are missed	0	1	2 3
Eating relieves fatigue	0	1	2 3
Feel shaky, jittery, or have tremors	0	1	2 3
Agitated, easily upset, nervous	0	1	2 3
Poor memory/forgetful	0	1	2 3
Blurred vision	0	1	2 3
Category VII			
Fatigue after meals	0	1	2 3
Crave sweets during the day	0	1	2 3
Eating sweets does not relieve cravings for sugar . .	0	1	2 3
Must have sweets after meals	0	1	2 3
Waist girth is equal or larger than hip girth	0	1	2 3
Frequent urination	0	1	2 3
Increased thirst and appetite	0	1	2 3
Difficulty losing weight	0	1	2 3
Category VIII			
Cannot stay asleep	0	1	2 3
Crave salt	0	1	2 3
Slow starter in the morning	0	1	2 3
Afternoon fatigue	0	1	2 3
Dizziness when standing up quickly	0	1	2 3
Afternoon headaches	0	1	2 3
Headaches with exertion or stress	0	1	2 3
Weak nails	0	1	2 3

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SMQEMAFD(1000)-NH/HS/MS/ND

*Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.
For nutritional purposes only.*

Category IX

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep ...	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category X

Tired, sluggish	0	1	2	3
Feel cold – hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight gain even with low-calorie diet ...	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals or excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XII

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms ...	0	1	2	3

Category XIII

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
“Splitting” type headaches	0	1	2	3

Category XIV (Males only)

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (Males only)

Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips ...	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XVI (Menstruating Females Only)

Are you perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle, greater than 32 days	Yes	No		
Shortened menses, less than every 24 days	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne breakouts	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XVII (Menopausal Females Only)

How many years have you been menopausal?				
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness or itching	0	1	2	3

How many alcoholic beverages do you consume per week? _____ How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____ How many times a week do you eat raw nuts or seeds? _____

How many times a week do you eat fish? _____ How many times a week do you workout? _____

List the three worst foods you eat during the average week: _____, _____, _____

List the three healthiest foods you eat during the average week: _____, _____, _____

Do you smoke? _____ If yes, how many times a day: _____

Rate your stress levels on a scale of 1-10 during the average week: _____

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions: