Patient Name: _____ Date: _____

Address: _____ City: _____ St: _____ Zip: _____

Email Address: _____ Ok to send email: Yes No

Phone: _____ Date Of Birth: _____

How did you find out about our weight loss program? _____

Are you currently pregnant, breast feeding, have active cancer, or cholecystitis? Yes No (***If yes, you are not eligible to participate in this program)***

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

___ High Blood Pressure	___ Chronic Pain	___Chronic Fatigue	___ Heartburn
___ History of Cancer	___ Neck Pain	___ Sleep Issues	___Constipation/Diarrhea
___ Heart Disease	___ Mid/Lower Back Pain	___ Anxiety/Irritability	___ Indigestion
___ High Cholesterol	___ Headaches	___ Mood Swings	___ Sinus/Allergy
___ Diabetes	___ Arthritis	___ Stiff, Sore Joints	___ Thyroid Problems

1. Current medications Condition Treating Date started
   _____
   _____
   _____
2. Current nutritional supplementation Date Started
   _____
   _____
   _____
3. Why do you currently want to lose weight?
4. How long have you struggled with your weight?
5. Previous weight loss plans Results
   _____
   _____
   _____
6. Do you have any other health challenges that you feel are important for us to know about?

CHIROTHIN WEIGHT LOSS PROGRAM 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 my physician or chiropractor 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 if I am pregnant or think I might be pregnant.

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 my physician.

I hereby release, discharge and agree to indemnify my physician(s), Dr. Daniel O'Leary, D.C., ChiroNutraceutical, 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.

Printed Name: _____

Signature: _____

Date: _____