DOCTOR SUPERVISED
CHIROTHIN
WEIGHT LOSS PROGRAM

NEW PATIENT FORM

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

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

1. Are you currently on any medications and for what health condition?

_____

2. Why do you currently want to lose weight?

_____

3. How long have you struggled with your weight?

_____

4. Have you tried other weight loss plans and if so, what have you tried?

_____

5. What were your results?

_____

6. How long did you keep the weight off?

_____

7. Do you currently take nutritional supplementation?
(if "yes" is the patient taking EFA's? They will need to discontinue EFA's while on this program)

_____

8. Do you have any other health challenges that you feel is 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 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), 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: _____

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ChiroThin™ Weight Loss Program Patient Declaration

Name (Last, First): _____ **Date (MM/DD/YEAR):** _____

I hereby consent to treatment and guidance while on the ChiroThin™ weight loss program. The ChiroThin™ Weight Loss Program is a Chiropractor-supervised weight loss program that is designed to maximize weight loss by using specific combinations and blends of specific low glycemic index/anti-inflammatory foods in combination with the ChiroThin™ nutritional support formula. I agree to follow the program designed or modified by the ChiroThin™ supervising health provider. I further agree to attend all scheduled weekly appointments. I understand that up to 6 appointments are included in the price of the entire program. I also understand that the cost of the program is designed to include the cost of supervision, program materials and supplies.

_____ **(Patient Initials)** _____ **(Doctor Initials)**

I agree to the following:

- I will eat every component of every meal as described.
- I will not skip any meals.
- I will take my drops as scheduled and will not miss taking them.
- I will not drink alcohol.
- I will take a daily multi vitamin and daily fiber tablets (to be approved by supervision doctor if not provided).
- I will not take any Essential Fatty Acid supplements while on the ChiroThin program.
- I will fill out my daily journal to be reviewed at the weekly sessions.
- I will drink my daily amount of recommended water.
- In order to achieve my desired goals, I agree not to quit or give up.
- I will be honest with myself and agree NOT TO DO things that are not in alignment with the program.

_____ **(Patient Initials)** _____ **(Doctor Initials)**

I understand that once I have started my weight loss program there are **NO** refunds. I also understand that my program is **NON-transferable.** I understand that weight loss is **NOT GUARANTEED** with this program, but that other patients have experienced positive results while on the program.

_____ **(Patient Initials)** _____ **(Doctor Initials)**

I understand that I undertake this program entirely at my own free will and risk and that my doctor will endeavor to take all due care. I understand that my doctor will rely on statements made by me to determine that the program is safe and will be effective for me. I have informed the doctor of all known physical and medical conditions as well as all medications that I am currently taking. I assume all responsibility and liability for any condition(s) or medication(s) I have failed to disclose.

_____ **(Patient Initials)** _____ **(Doctor Initials)**

I hereby waive any potential claim for liability against the doctor and the makers of ChiroThin, and freely accept all liability and responsibility for my results while on this program.

Patient Signature: _____

Witness Signature: _____