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
- ❑ Cancer
- ❑ Heart Disease
- ❑ Fibromyalgia
- ❑ Hip/Knee Pain
- ❑ Gallbladder Issues
- ❑ Gas/Bloating/Belching
- ❑ High Cholesterol
- ❑ Consume Alcohol
- ❑ Take OTC Meds
- ❑ Heartburn/GERD
- ❑ Allergies
- ❑ Prone to Colds/Flu
- ❑ Irregular Bowels/ Constipation
- ❑ Prone to Kidney Infections
- ❑ Diabetes
- ❑ Neck Pain
- ❑ Digestive Problems
- ❑ Numbness
- ❑ Osteoporosis
- ❑ Headaches
- ❑ Upper Back Pain
- ❑ Arthritis
- ❑ Stress/Irritability
- ❑ Chronic Inflammation
- ❑ Hypoglycemia
- ❑ Thyroid Problems
- ❑ Chronic Fatigue
- ❑ Sinus/Allergy
- ❑ 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?

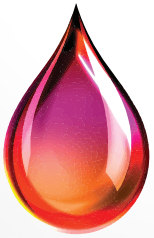
_____

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

_____

5. What were your results?

_____



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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

The individual named below (referred to as "I" or "me") desires to participate in the ChiroThin Weight Loss Program (the "Activity"). In consideration of being permitted to participate in the Activity and in recognition of the ChiroThin's reliance hereon, I agree to all the terms and conditions set forth in this instrument (this "Release"). I understand participation in the Activity and 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, gallbladder issues, loss of consciousness, shortness of breath and other ailments. I understand rapid weight loss of over 1-2 lbs. per week is considered 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 will not 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 understand 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 if I experience any ailment, including but not limited to those listed above, I should immediately stop using or consuming the ChiroThin product and 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 or chiropractor. I further agree not to use or consume any ChiroThin product without the advice, counsel, and recommendations of my physician. I hereby waive, release and discharge my physician(s), ChiroNutraceutical, Inc. (the "Company"), their agents, servants, employees and affiliates (together the "Releasees") 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 participation in the Activity. I covenant not to make or bring any such claim against the Company or any other Releasee. I shall defend, indemnify, and hold harmless the Company, and all other Releasees, against any and all losses, damages, liabilities, deficiencies, claims, actions, judgments, settlements, interest, awards, penalties, fines, costs, or expenses of whatever kind, including attorney fees, fees, the costs of enforcing any right to indemnification under this Release, and the cost of pursuing any insurance providers, incurred by the Company, or any other Releasees, arising out or resulting from any claim of a third-party related to my participation in the Activity, including any claim related to my own negligence or the ordinary negligence of the Company.

BY SIGNING, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTOOD ALL OF THE TERMS OF THIS RELEASE

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: _____

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Patient Name: _____ Date: _____

Patient's Height in Inches: _____ Patient's Age: _____

Patient's Current Weight: _____ Patient's Goal Weight: _____

Calculate Patient's Current BMI: (Weight in Pounds x 703) ÷ (height in inches x height in inches)

Patient's Current BMI: _____ Patient's Goal BMI: _____

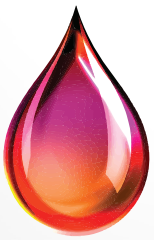
Initial Visit Date: _____

BODY INCHES MEASUREMENT CHART

	START	WEEK 1	WEEK 2	WEEK 3	WEEK 4	WEEK 5	WEEK 6	TOTAL LOST
NECK								
SHOULDER								
CHEST								
BICEP								
WAIST								
HIPS								
UPPER THIGH								
CALF								

Start Date: _____

Weight: _____ BP: _____ / _____ Pounds Lost: _____ Inches Lost: _____ BMI: _____



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Week 1 Date: _____

Weight: _____ BP: _____ / _____ Pounds Lost: _____ Inches Lost: _____ BMI: _____

Challenges/Concerns and Recommendations: _____

_____

_____

Week 2 Date: _____

Weight: _____ BP: _____ / _____ Pounds Lost: _____ Inches Lost: _____ BMI: _____

Challenges/Concerns and Recommendations: _____

_____

_____

Week 3 Date: _____

Weight: _____ BP: _____ / _____ Pounds Lost: _____ Inches Lost: _____ BMI: _____

Challenges/Concerns and Recommendations: _____

_____

_____

Week 4 Date: _____

Weight: _____ BP: _____ / _____ Pounds Lost: _____ Inches Lost: _____ BMI: _____

Challenges/Concerns and Recommendations: _____

_____

_____

Week 5 Date: _____

Weight: _____ BP: _____ / _____ Pounds Lost: _____ Inches Lost: _____ BMI: _____

Challenges/Concerns and Recommendations: _____

_____

_____

Week 6 Date: _____

Weight: _____ BP: _____ / _____ Pounds Lost: _____ Inches Lost: _____ BMI: _____

Challenges/Concerns and Recommendations: _____

_____

_____

Total Pounds Lost: _____ **Total Inches Lost:** _____

Ending BMI: _____ **Ending BP:** _____/_____

H.E.A.L
Health. Energy. Alignment. Longevity
with Chiropractic

I _____, understand that nutritional supplements and professional protocols that I received are non-refundable. Once the product is ordered I understand it is my possession. I understand I am receiving a package price, and if the program is not completed standard pricing will apply. I understand that to get full results with my condition, I must follow the recommendations as outlined in the program materials and as directed by our team.

Signature _____ Date _____

Package Chosen _____ Price _____