Name: **WM Follow Up Intake Form**

1. **Are you feeling better overall?** ☐ Yes ☐ No
2. **Are your clothes fitting more loosely?** ☐ Yes ☐ No
3. **Are you following the nutritional plan outlined by our handout?** ☐ Yes ☐ No
4. **Have you experienced any side effects?**
   ☐ Constipation ☐ Headaches ☐ Dry Mouth ☐ Muscle Cramps ☐ Other:
5. **Are you keeping a food journal?** ☐ Yes ☐ No
6. **Are you exercising?** ☐ Yes ☐ No
7. **Are you sleeping well?** ☐ Yes ☐ No
8. **Have you had any blood work done since your last visit?** ☐ Yes ☐ No
9. **Have you stopped any medication or started any new medications since our last visit?**
   ☐ Yes ☐ No If yes, please explain:
10. **Are you having any of the following?**
    ☐ Fatigue ☐ Joint Pain ☐ Snoring ☐ Shortness of Breath

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