Name____
Address____
City______________________________ State______________ Zip___________________
Telephone-Home (____) __________________ Mobile (____) _____________
Email_______________________________________ I would like to receive digital communication: YES or NO
DOB (MM/DD/YY) ____________________ Age____________ Height___ft___in
Occupation____________________________ Spouse Occupation________________________________
How were you referred to our office? ____
Are you taking any medication? YES NO
If yes, please list medication name and dosage, if more space is need use back of page:
____
____
____
Do you have any known allergies? YES NO
If yes, please list known allergies: ____
Do you wear a pacemaker? YES NO
Are you pregnant? YES NO Are you breast feeding? YES NO

MEDICAL HISTORY

Do you or any family member have/had any of the following? If Family use "F", Personally use "**X**"

_____Heart Attack	_____Gout	_____High Cholesterol
_____Diabetes* (If yes, is it under control? YES NO)	_____Hypoglycemia	_____Headache
_____Thyroid Disease	_____Anemia	_____Poor Sleep
_____Gallbladder Disease	_____Cancer	_____Arthritis
_____Kidney Disease	_____High Blood Pressure* (If yes, does it require more than 2 medications? YES NO)	_____Shortness of Breath
_____Stroke	_____Low Blood Pressure*	_____Intestinal Problems
_____Grave's Disease*	_____Weak/Compromised Immune system*	_____Depression

Has your Primary Care Physician recommended you to lose weight? YES NO
Primary Care Physician name and address: ____
____

HISTORY

How long have you been overweight? _______________________
Can you attribute your weight gain to anything specific? ____
Have you tried to lose weight in the past? YES NO
If yes, please list programs/methods____
What are your top 2 reasons **WHY** you want to lose weight? ____
____
What would prevent you from starting our program today? ____
____
Do you take vitamins or other food supplements when you diet? _____ Yes _____ No
Which describes you best?
I eat too much: ______ When Nervous ______ For Pleasure ______ When Upset _____________Other

Please take a moment and summarize what you normally eat for:

Breakfast____

Mid-morning____

Lunch____

Mid-Afternoon____

Dinner____

Evening____

GOALS

What is your current weight? ______________ What is your goal weight? ________________________

When was the last time you were at that weight? ____

How much have you lost and gained and then lost and gained in the past? _________________________

On a scale of 1-10, with 10 meaning – I'm fully committed to losing weight and getting healthy, what is your commitment level? ____

Signature____ Date ____________________

CONGRATULATIONS on taking the 1st step in changing your life!