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
_____Diabetes*
(If yes, is it under control? YES NO)
_____Thyroid Disease
_____Gallbladder Disease
_____Kidney Disease
_____Stroke
_____Grave's Disease*****

_____Gout
_____Hypoglycemia
_____Anemia
_____Cancer
_____High Blood Pressure*
(If yes, does it require more than 2 medications? YES NO)
_____Low Blood Pressure*
_____Weak/Compromised Immune system*

_____High Cholesterol
_____Headache
_____Poor Sleep
_____Arthritis
_____Shortness of Breath
_____Intestinal Problems
_____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!