Date: _____

PERSONAL INFORMATION

CUSTOM FAT LOSS

____ Dr. ____ Mr. ____ Mrs. ____ Ms. ____ Miss

Name:	Telephone:	
Address:	City State: Zip:	
Email:		
Date of Birth:	Age:	Height:
Occupation:	Employer:	

Where did you hear about us? Radio: Station _____ Social Media: _____ Family/Friend: _____

MEDICAL HISTORY

Have you had ANY surgery in the past? Please Explain:

Are you taking any medications? If yes, please list:

Do you have a ***Pace maker*** or any ***Implanted Medical Device*** ? Please Explain:

Do you or any family member have/had any of the following? Label **S** for self and **F** for family

	Anemia		Diziness		High Blood Pressure		Neck Pain
	Arthritis		Epilepsy		High Cholesterol		PCOS
	Cancer		Gall Bladder Disease		Hypoglycemia		Poor Sleep
	Carpal Tunnel		GERD		Intestine problems		Shortness of Breath
	Depression		Gout		Kidney Disease		Stroke
	Diabetes Type 1		Headache		Low Back Pain		Thyroid Disease
	Diabetes Type 2		Heart Attack		Mid Back Pain		

PRIMARY CARE PHYSICIAN

Name:	Address:
Current Insurance Carrier:	

ALLERGIES

Please list all allergies:

HISTORY

How does your current weight/health negatively impact your life?

1 _____

2 _____

3 _____

Have you been successful losing weight in the past?

1 _____

2 _____

What have you done to lose weight in the past?

1 _____

2 _____

What are your top two reasons for losing weight?

1 _____

2 _____

What do you believe is preventing you from achieving your goals?

1 _____

2 _____

Has your Doctor recommended you to lose weight?

Yes No

Can you attribute your weight gain to anything specific?

_____

GOALS

What is your Goal Weight? _____ On a scale of 1-10 with 10 meaning- I am FULLY committed, I want to start right now!

What is your current level of commitment? 10 9 8 7 6 5 4 3 2 1