Today's Date_____ How did you hear of us:_____

For Office Use Only:
W: _____ BF%:_____
Weight Goals:_____ HL: _____

Weight loss can be complex. The following information will help us build a plan that is *right for you*.

Please indicate your current level of commitment to your weight loss goals:

(not committed) 1 2 3 4 5 6 7 8 9 10 (highly committed)

☐☐☐☐☐☐☐☐☐☐

Check all that you experience:

- ☐Fatigue
- ☐Difficulty falling asleep
- ☐Difficulty staying asleep
- ☐High amounts of stress
- ☐Over heating
- ☐Cold hands and feet
- ☐Low sex drive
- ☐Abdominal Pain
- ☐Diarrhea
- ☐Sugar Cravings
- ☐Irritable if meals are missed
- ☐Fatigue after meals
- ☐Fibromyalgia
- ☐Depression
- ☐Mental fatigue
- ☐Menopause
- ☐Knee pain
- ☐Hip pain
- ☐Take pain medication
- ☐Constipation
- ☐Gas after a meal
- ☐Back pain
- ☐Joint pain
- ☐Muscle pain
- ☐Frequent Urination

Current Medications:

_____

_____

_____

Past Surgeries:

_____

_____

Name_____**Occupation**_____

Address_____**City**_____**Zip**_____

Cell phone:_____**Home phone:**_____

Age:_____ **Height:** _____ **Weight:**_____

Email:_____