

Today's Date \_\_\_\_\_

How did you hear of us: \_\_\_\_\_

For Office Use Only:

W: \_\_\_\_\_

BF%: \_\_\_\_\_

Weight Goals: \_\_\_\_\_

HL: \_\_\_\_\_

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)

**Weight loss can be complex. If you have failed in the past, it could be because you have some of the following:**

Check all that apply:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Fatigue                     | <input type="checkbox"/> Irritable if meals are missed | <input type="checkbox"/> Constipation       |
| <input type="checkbox"/> Difficulty getting to sleep | <input type="checkbox"/> Fatigue after meals           | <input type="checkbox"/> Gas after a meal   |
| <input type="checkbox"/> Difficulty staying asleep   | <input type="checkbox"/> Fibromyalgia                  | <input type="checkbox"/> Back pain          |
| <input type="checkbox"/> High amounts of stress      | <input type="checkbox"/> Depression                    | <input type="checkbox"/> Joint pain         |
| <input type="checkbox"/> Over heating                | <input type="checkbox"/> Mental fatigue                | <input type="checkbox"/> Muscle pain        |
| <input type="checkbox"/> Cold hands and feet         | <input type="checkbox"/> Menopause                     | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> Low sex drive               | <input type="checkbox"/> Knee pain                     |   |
| <input type="checkbox"/> Abdominal Pain              | <input type="checkbox"/> Hip pain                      |   |
| <input type="checkbox"/> Diarrhea                    | <input type="checkbox"/> Take pain medication          |   |
| <input type="checkbox"/> Sugar Cravings              |  |   |

Current Medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Past Surgeries:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone where you can be reached \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ feet, \_\_\_\_\_ inches

Email \_\_\_\_\_