First Name: _____ Last Name: _____

Email: _____Phone: _____Birthdate: _____

Address: _____City_____Zip Code_____

How did you hear about us? _____

**Office Use: Height_____ Weight _____ BMI _____ Fat % _____**

What important reason or goal date do you have to lose weight? _____

How many pounds would you like to lose? _____

Does your family support your weight loss efforts? _____ YES _____ NO

Hove you been advised by your family physician to lose weight? _____ YES _____ NO

# Health Information

Past or Present Health Conditions (**Please check all that apply**):

_____ Anorexia/bulimia

_____ Blood Clots

_____Cancer (if yes list type_____)

_____ Diabetes

_____Drug/alcohol addiction

_____Gallbladder disease

_____ Glaucoma/retinopathy

_____ Heart attack/heart disease

_____ High Blood Pressure

_____ Hypoglycemia

_____ Kidney disease

_____ MEN 2 personal or family history

_____ Pancreatitis

_____ Thyroid disease (personal or family)

_____ Tumor of the thyroid/parathyroid/pituitary/pancreas/adrenal glands (if yes circle which organ)

_____ Stroke

_____ Currently pregnant or Nursing _____ Actively trying to become pregnant.

List allergies to any medications. _____

**Please list all medications you are currently taking, including doses and reasons for taking**

| **Medication:** | **Dose:** | **How Often:** | **Reason:** | |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

## Current Symptoms: **Please check any symptoms you are now experiencing**.

**Weight:**

___ Inability to lose weight

___ Food Cravings

___ Binge eating

___ Nausea or vomiting

___ Water retention

___ Alcohol consumption

**Digestive Symptoms:**

___Stomach pains or cramping

___Constipation (chronic)

___Diarrhea

___ Reflux or heartburn

___Bloating

___Gas

**Head and Ears:**

___ Migraines

___Headaches

___Wheezing

**Sinus and Respiratory:**

___Asthma

___Chest congestion

___Chronic cough

___Frequent sneezing

**Emotional and Mental:**

___Depression

___Anxiety

**Energy:**

___Fatigue

___Lethargy

___Restlessness

___Insomnia

___Hyperactivity

**Other Symptoms:**

___Irregular Heartbeat

___Chest Pains

Please list any symptoms you experience that were not previously mentioned:

_____

_____

_____ _____

**Signature:** **Date:**