Patient Name: _____ Date: _____

What you prefer to be called: _____ ___Male ___Female

Address: _____ City: _____ St: _____ Zip: _____

Phone_____ Email Address: _____ Ok to send email: Yes No

Date Of Birth: _____ Age: _____ Employer: _____

How did you find out about our weight loss program? _____

Do you experience any of the following conditions even if they are minor and go away on their own?

| | | | |
|---|---|---|---|
| ___ High Blood Pressure | ___ Diabetes | ___ Headaches | ___ Hypoglycemia |
| ___ Cancer | ___ Neck Pain | ___ Back Pain | ___ Thyroid Problems |
| ___ Heart Disease | ___ Digestive Problems | ___ Arthritis | ___ Chronic Fatigue |
| ___ Fibromyalgia | ___ Numbness | ___ Stress/Irritability | ___ Sinus/Allergy |
| ___ Hip/Knee Pain | ___ Osteoporosis | ___ Chronic Inflammation | ___ Other |

1. Are you currently pregnant or breast feeding? Yes No (If yes, you are not eligible to participate in this program)

2. Do you have active cancer, or cholecystitis (gallbladder issues or gallstones)? Yes No (If yes, you are not eligible to participate in this program)

3. Are you currently on any medications and for what health condition?

4. Why do you currently want to lose weight?

5. How long have you struggled with your weight?

6. Have you tried other weight loss plans and if so, what have you tried?

7. What were your results?

8. How long did you keep the weight off?

9. Do you currently take nutritional supplementation? (if “yes” is the patient taking EFA’s [FISH OIL]? They will need to discontinue EFA’s while on this program)

10. Do you have any other health challenges that you feel is important for us to know about?