

Today's Date _____

How did you hear of us: _____

For Office Use Only:

W: _____

BP: _____

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

Current Medications:

Past Surgeries:

Name _____ Occupation _____

Address _____ City _____ Zip _____

Phone where you can be reached _____

Age: _____ Height: _____ feet, _____ inches Weight _____

Email _____

Are You on Facebook? _____