LIVE LEAN!
Take Control
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Dr._____ Mr._____ Mrs._____Ms._____ Miss_____

Patient Name: _____Date: _____

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

Email Address: _____ Ok to send email: Yes No

Telephone Home:_____ Cell:_____ Date Of Birth: _____ Age_____

Height: _____How did you find out about our weight loss program? _____

Occupation:_____ Spouse Occupation_____

Employed By_____

Are you currently pregnant, breast feeding, have active cancer, or cholecystitis? Yes No

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

___ High Blood Pressure	___ Diabetes	___ Shortness of Breath	___ Numbness
___ Cancer	___ Hypoglycemia	___ Gall Bladder Disease	___ Back/Neck Pain
___ Heart Disease	___ Digestive Problems	___ Arthritis	___ Chronic Fatigue
___ Kidney Disease	___ Stroke	___ Headaches	___ Sinus/Allergy
___ High Cholesterol	___ Gout	___ Allergies	___ Osteoporosis
___Thyroid Problems	___ Anemia	___ Poor Sleep	___ Other

1. Have you had any surgeries in the past?_____
2. How much water typically do you drink per day?_____
3. Are you currently on any medications?
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. How long did you keep the weight off?
8. What is your average energy level? (on a scale of 1-10 with 10 being the highest)
9. Do you currently take nutritional supplementation? **(if "yes" are you taking EFA's? You will need to discontinue EFA's while on this program)**
10. What is your Goal Weight?
11. On a scale of 1-10 with 10 being the highest, What is your commitment level?_____
12. Do you Have a pacemaker? _____Yes _____No