

Melt That Fat Away

(Please Print Clearly)

Your Name:	Referred by:	Today's Date:
Address:		City:
		State:
		Zip:
Home #:		Work #:
		Cell #:
Email Address:		
Height:	Weight: of Birth: Age:	Date Sex:
Marital Status:	Are you pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes, how far along?	
How much water do you consume per day?		
Occupation:	How many hours per week do you work?	
Are you currently under the care of a physician? <input type="checkbox"/> No <input type="checkbox"/> Yes, for what reason(s):		
How stressed are you? (On a scale of 1 to 10, where 10 is the worst):		
Have you ever had any health conditions that affected your liver? <input type="checkbox"/> No <input type="checkbox"/> Yes, explain:		
Have you ever had cancer? <input type="checkbox"/> No <input type="checkbox"/> Yes, explain:		
Do you exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes, how often?	What type?	
Which do you want us to focus on? <input type="checkbox"/> Abdomen <input type="checkbox"/> Buttocks <input type="checkbox"/> Thighs <input type="checkbox"/> Chest <input type="checkbox"/> Arms <input type="checkbox"/> Neck <input type="checkbox"/> Cellulite		
How long have you been overweight?		
How much weight do you want to lose?		
Are you embarrassed about your weight/appearance? <input type="checkbox"/> No <input type="checkbox"/> Yes, explain:		
How important is weight or size reduction to you? (On a scale of 1 to 10, where 10 is the most important)		
Are other members of your family overweight? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Do you feel tired, run down, or out of energy? <input type="checkbox"/> No <input type="checkbox"/> Yes, explain:		

I clearly understand and agree that all services rendered are charged directly to me, and that I am personally responsible for payment.

Your Name (print): _____

Signature: _____ Date: _____

----- DO NOT WRITE BELOW THIS POINT -----

Provider's Notes: