



FOR CONSULTANT USE	WEIGHT _____
_____ - _____ WKS	GOAL WT _____
	LBS TO LOSE _____

I. PERSONAL INFORMATION Date _____ Email _____

Name _____ Home Phone _____ Cell _____

Address _____ Age _____ DOB _____ Occupation _____

City _____ State _____ Zip _____ Children in the household Y or N _____ Marital Status _____

Does your Company offer Flex Pay or Health Savings? Y or N Are you currently enrolled with Care Credit? Y or N
 If No, Are you familiar with Care Credit? (Medical Payment Plan) Y or N

How did you hear about us? Physician Referral _____ Newspaper _____ Radio _____ Commercial _____ Sign _____ Referral _____ Web _____
 Other _____ If other, how did you hear about us? _____

II. HEALTH HISTORY

Personal Physician _____ Date of Last Exam _____

Current Medications including vitamins/herbs _____

Do you have any food or drug allergies? Circle if allergic or intolerant: Eggs- Aspartame - Milk – Soy- Shellfish -
 Pineapple - Iodine - Tyramine - Chocolate – Sulfa - Gluten –Nuts – Wheat - Other _____

Any prescription or over the counter diet medications you have used in the past _____

Has your physician advised that you lose weight or prescribed any specific diet restrictions for you? Y or N

If Yes, please list here _____

Are you under a physician’s care for any acute or chronic medical condition requiring treatment? Y or N

III. WEIGHT LOSS HISTORY

1. How long have you been thinking about losing weight? _____

2. How long have you been overweight? _____ Lowest Weight _____ Highest Weight _____

3. What would you like to weigh? _____ Your Height? _____

4. Why do you want to lose weight? Doctor recommendation _____ Self Esteem _____ Upcoming Event _____ Health _____ Look Better _____
 OTHER REASON _____

5. Previous methods of weight reduction and results _____

6. Is your husband/wife/family member overweight? _____ Are they supportive of you losing weight? _____

IV. EATING HABITS & PHYSICAL NEEDS

1. What are your favorite foods? _____

2. Do you tend to eat more during the day or at night? _____

3. Have you noticed a decrease in your concentration and memory? Y or N

4. Do you crave carbohydrates? i.e. bread, pasta, cereal, etc. Y or N

5. Do you have problems sleeping at night? Y or N

6. What areas of your body are you most concerned about in regards to your weight?
 Shoulders _____ Upper back _____ Stomach _____ Lower back _____ Hips _____ Thighs _____ Buttocks _____ Other _____

7. How many meals do you eat per day? _____ How many snacks? _____

V. BEHAVIORAL HABITS

1. Have you ever successfully lost weight only to regain that weight over time? Y or N

2. I am an ‘emotional eater’. I eat when I am upset, angry, sad, etc Y or N

3. Your chances for success would increase if you understood more about why you overeat? Y or N

4. Would you like to learn more about ‘why’ you overeat? Y or N

5. Changing the way that you eat takes both ‘mental’ and ‘physical’ change to discipline
 Strongly Agree Slightly Agree Agree Slightly Disagree Strongly Disagree

6. On a Scale from 1-10, (10 being the highest) what role do you feel the mind play in successful weight management? _____

7. What percent of successful weight management do you feel involves changing the way you think?
 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

8. On a scale of 1 to 10 (10 being the highest) how committed are you to losing weight? _____

SECTION I

ANGINA PECTORIS	Y or N	INTESTINAL DISORDERS:	
Relieved with Nitro	Y or N	Crohn's Disease (diagnosed)	Y or N
Relieved without Nitro	Y or N	Colitis/Irritable Bowel Syndrome	Y or N
ANOREXIA or BULIMIA, active	Y or N	Ulcerative Colitis	Y or N
BLOOD DISORDERS:		Severe Ileitis	Y or N
Hemophilia or Leukemia	Y or N		
KIDNEY		Ever had GASTRIC BYPASS	Y or N
Dialysis/Kidney failure/Uremia	Y or N	CIRRHOSIS or LIVER DISEASE	Y or N
CURRENTLY PREGNANT	Y or N	HEPATITIS, ACTIVE	Y or N
PSYCHIATRIC DISEASE	Y or N	LUPUS	Y or N
HIV POSITIVE OR AIDS	Y or N	SPASTIC COLON (Diagnosed)	Y or N
HEART ATTACKS within last 12 months	Y or N	SKIN CANCER, active within 1 yr	Y or N
EPILEPSY (uncontrolled)	Y or N	MULTIPLE SCLEROSIS	Y or N

SECTION II

INSULIN DEP. DIABETES TYPE 1	Y or N	CARDIOVASCULAR	
DIABETIC TYPE II	Y or N	Post Stroke (Within 1 year)	Y or N
Oral Meds	Y or N	Cardiovascular Disease	Y or N
Diet Controlled	Y or N	Abnormal readings on an EKG	Y or N
GOUT/High Uric Acid	Y or N	Heart Attack within last 10 years	Y or N
BREASTFEEDING	Y or N	Peripheral Vascular Disease	Y or N
LYMPHOMA	Y or N	LIVER – Hepatitis nonactive within 1 yr	Y or N
FIBRIOD CYSTS	Y or N	INTESTINAL DISORDER + Allergic to Soy	Y or N
PORPHYRIA BLOOD DISORDER	Y or N	CANCER (other than skin, nonactive)	Y or N
SOY ALLERGIES with no Intestinal disorder	Y or N	HYPOGLYCEMIA	Y or N
ACTIVE ALCOHOLIC	Y or N	CHRONIC CONSTIPATION	Y or N
BLADDER/GALL BLADDER DISEASE	Y or N	GLUTEN ALLERGY	Y or N
KIDNEY STONES (within 1 yr)	Y or N		
Ever had GALL STONES or Family History	Y or N	PAST HISTORY OR PRESENTLY TAKING	
Only ONE Functioning Kidney	Y or N	Cholesterol Medications	Y or N
Ever been referred to a Renal Specialist	Y or N	Hormone Replacement Therapy	Y or N
ULCER (in last 12 weeks)	Y or N	3 or MORE Blood Pressure Medications	Y or N

SECTION III

ANESTHESIA within the last 2 Weeks	Y or N	HYPOTHYROIDISM	Y or N
ARTHRITIS	Y or N	IRREGULAR HEART BEAT	Y or N
ASTHMA	Y or N	LACTOSE INTOLERANCE	Y or N
CELIAC DISEASE	Y or N	MIGRAINES (diagnosed, uncontrolled)	Y or N
CORTISONE THERAPY	Y or N	MITRAL VALVE PROLASE	Y or N
ENLARGED PROSTATE OR		PACE MAKER	Y or N
DIFFICULTY URINATING		SPASMS	Y or N
EPILEPSY (controlled)	Y or N	STOMACH SURGERY	Y or N
Ever had a Complete Blood Work UP	Y or N	Ulcer - within 3 years	Y or N
FIBROMYALGIA	Y or N	Staple – within 2 years	Y or N
GLAUCOMA	Y or N	THROMBOPHLEBITIS	Y or N
HIATAL HERNIA	Y or N	VEGETARIAN	Y or N
HYPERTHYROIDISM	Y or N	WILSONS DISEASE	Y or N

Are you currently on any of the following prescriptions:

Mood Elevating Drugs	Y or N	Insulin	Y or N
MAOI	Y or N	Diuretics	Y or N
Blood Thinners	Y or N	Antipsychotics	Y or N
Synthroid or Synthroid Type Med	Y or N	Antiulcer	Y or N
High Blood Pressure Medication	Y or N	Anticonvulsants	Y or N
Asthma Medication	Y or N	Antianginas	Y or N

Is there any additional information you believe we should be aware of in considering you for this program?

I reviewed my responses and they are true to the best of my knowledge. I understand that this information is to be used to assist Medical Weight Loss (referred to herein as "MWLS"), in providing an effective dietary program and online support via newsletters and emails. I also understand MWLS will not provide medical treatment. I understand that my weight loss success may be discussed to other patients or prospects for, but not limited to, encouragement purposes for others. I have been advised that it is important for anyone who has a health problem and wants to lose weight to consult a physician before or starting this or any weight loss program. If I am taking medication, I understand that a weight loss program can affect my need for the medication. My physician may want to make changes in my treatment or medication. I agree to inform MWLS of any changes in my health status, physical condition, or medication. I take full responsibility for my actions and do not hold MWLS responsible in any way.

DATE _____ SIGNATURE _____ PRINT NAME _____