



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

PERSONAL INFORMATION Date _____ Email _____

Name _____ Home Phone _____ Cell _____

Address _____ Age _____ DOB _____ Marital Status _____

City _____ State _____ Zip _____ Occupation _____

Does your Company offer Flex Pay? Y or N Are you currently enrolled with Care Credit? Y or N

How did you hear about us? Physician Referral _____ Newspaper _____ Radio _____ Commercial _____ Sign _____ Referral _____ Other _____

I. HEALTH HISTORY

Personal Physician _____ Date of Last Exam _____

Current Medications including vitamins/herbs _____

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

II. WEIGHT LOSS HISTORY

How long have you been thinking about losing weight? _____

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

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

Why do you want to lose weight? Doctor recommendation ___ Self Esteem ___ Upcoming Event ___ Health ___ Look Better ___

OTHER REASON _____

Previous methods of weight reduction and results _____

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

V. EATING HABITS

What are your favorite foods? _____

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

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

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

Do you have problems sleeping at night? Y or N

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 ___

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

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

PLEASE CHECK YES IF YOU HAVE BEEN DIAGNOSED WITH ANY OF THE FOLLOWING

SECTION I

ANGINA PECTORIS	Y or N	INTESTINAL DISORDERS:	
Relieved with Nitro	Y or N	Chrohn'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
Hemophila or Leukemia	Y or N		
Porphyria	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
PREGNANT	Y or N	HEPATITUS, 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

PLEASE CHECK YES IF YOU HAVE BEEN DIAGNOSED WITH ANY OF THE FOLLOWING

SECTION II

INSULIN DEP. DIABETES TYPE 1 Y or N
DIABETIC TYPE II Y or N
 Oral Meds Y or N
 Diet Controlled Y or N
OUT/High Uric Acid Y or N
BREASTFEEDING Y or N
LYMPHOMA Y or N
INTESTINAL DISORDER + Allergic to Soy Y or N
FOOD ALLERGIES with no Intestinal disorder Y or N
ACTIVE ALCOHOLIC Y or N
BLADDER/GALL BLADDER DISEASE Y or N
KIDNEY STONES (within 1 yr) Y or N
Ever had GALL STONES or Family History Y or N
Only ONE Functioning Kidney Y or N
Ever been referred to a Renal Specialist Y or N
ULCER (in last 12 weeks) Y or N

CARDIOVASCULAR

Post Stroke (Within 1 year) Y or N
 Cardiovascular Disease Y or N
 Abnormal readings on an EKG Y or N
 Heart Attack within last 10 years Y or N
 Peripheral Vascular Disease Y or N
LIVER – Hepatitis nonactive within 1 yr Y or N
CANCER (other than skin, nonactive) Y or N
HYPOGLYCEMIA Y or N
CHRONIC CONSTIPATION Y or N
GLUTEN ALLERGY Y or N
PAST HISTORY OR PRESENTLY TAKING
 Cholesterol Medications Y or N
 Hormone Replacement Therapy Y or N
 Birth Control Y or N
 3 or MORE Blood Pressure Medications Y or N

SECTION III

ANESTHESIA within the last 2 Weeks Y or N
ARTHRITIS Y or N
ASTHMA Y or N
CELIAC DISEASE Y or N
CORTISONE THERAPY Y or N
ENLARGED PROSTATE OR
DIFFICULTY URINATING
EPILEPSY (controlled) Y or N
Ever had a Complete Blood Work UP Y or N
EMBRIOD CYSTS Y or N
EMBROMYALGIA Y or N
GLAUCOMA Y or N
HIATAL HERNIA Y or N
HYPERTHYROIDISM Y or N

HYPOTHYROIDISM Y or N
IRREGULAR HEART BEAT Y or N
LACTOSE INTOLERANCE Y or N
MIGRAINES (diagnosed, uncontrolled) Y or N
MITRAL VALVE PROLASE Y or N
PACE MAKER Y or N
SPASMS Y or N
STOMACH SURGERY Y or N
 Ulcer - within 3 years Y or N
 Staple – within 2 years Y or N
THROMBOPHLEBITIS Y or N
VEGETARIAN Y or N
WILSONS DISEASE Y or N

Are you currently on any of the following prescriptions:

Food Elevating Drugs Y or N
MAOI Y or N
Blood Thinners Y or N
Synthroid or Synthroid Type Med Y or N
High Blood Pressure Medication Y or N
Asthma Medication Y or N

Insulin Y or N
Diuretics Y or N
Antipsychotics Y or N
Antiulcer Y or N
Anticulsants Y or N
Antianginas Y or N

3. Please list any prescription or over the counter diet medications you have used in the past _____

4. 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 _____

5. Has your physician advised that you lose weight or prescribed any specific diet restrictions for you? Please list here _____

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

I have 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 Solutions (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 have been advised that it is important for anyone who has a health problem and wants to lose weight to consult a physician before 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 _____

DATE _____ SIGNATURE _____ PRINT NAME _____

Parent/Guardian if client is a minor)