Medical Weight Loss
HEALTHOGENICS®

FOR CONSULTANT USE:
Weeks_____ Goal Weight_____
Pounds to Lose_____

Date_____ Email_____

Name_____ Home Phone_____ Cell_____

Address_____ Age_____ DOB_____ Occupation_____

City_____ State____ Zip_____ Children in Household Y or N_____ Marital Status_____

Circle how you heard about us: Physician Website Internet Radio TV Sign Referral Other_____
Does your Company offer Flex Pay or Health Savings? Y or N Are you currently enrolled with Health Savings? Y or N
Are you familiar with Care Credit? Y or N Are you currently enrolled with Care Credit? Y or N

Circle any/all food allergies or intolerances: Eggs Aspartame Milk Soy Shellfish Pineapple Iodine Sulfa
Sulfur Gluten Nuts Wheat Amino Acids Other_____

Are you currently on any of the medications?

MAOI	Y or N	Blood Pressure Medication	Y or N
Blood Thinners	Y or N	Antipsychotics	Y or N
Diuretics	Y or N	Diabetic or Insulin Medication	Y or N
Asthma	Y or N	Heart Medication	Y or N
Antiulcer	Y or N	Synthroid or Synthroid Type Medication	Y or N
Anticonvulsants	Y or N	Mood Elevator/Antidepressant	Y or N
Anti-anginas	Y or N	Medications that cause photosensitivity*	Y or N
Currently on Anesthesia	Y or N	Adipex, Phentermine, Bontril, Phenteramine	Y or N
		ADD/ADHD Medication	Y or N

List any other medications or herbs and vitamins you are taking other than those listed above:

_____

A. WEIGHT LOSS HISTORY

How long have you been thinking about losing weight? _____
How long have you been overweight?_____ Lowest Adult Weight_____ Highest Weight_____
What would you like to weigh?_____ Your Height_____
Circle why do you want to lose weight? Self Esteem Event Health Look Better Other
Previous methods of weight reduction and results_____
Why do you think you are overweight? _____
Is your husband/wife/family member overweight?_____ Are they supportive of you losing weight? _

B. 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? _____

C. BEHAVIORAL HABITS

Have you ever successfully lost weight only to regain that weight over time? Y or N
I am an 'emotional eater'. I eat when I am upset, angry, sad, etc Y or N
Your chances for success would increase if you understood more about why you overeat? Y or N
Changing the way that you eat takes both 'mental' and 'physical' change to discipline
Strongly Agree Slightly Agree Agree Slightly Disagree Strongly Disagree
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%
On a scale from 1-10 (10 being the highest), how committed are you to losing weight? _____

SECTION I

CURRENTLY PREGNANT*	Y or N	HIV POSITIVE OR AIDS *	Y or N
EPILEPSY, Gran Mal, Uncontrolled*	Y or N	PSYCHIATRIC DISEASE	Y or N
		EPILEPSY (controlled)	Y or N

SECTION II

DIABETIC TYPE I*	Y or N	SOY ALLERGY	Y or N
DIABETIC TYPE II	Y or N	CIRRHOSIS or LIVER DISEASE*	Y or N
BREASTFEEDING*	Y or N	PERIPHERAL VASCULAR DISEASE	Y or N
LYMPHOMA	Y or N	HEPATITUS	Y or N
FIBROID CYSTS	Y or N	HYPOGLYCEMIA	Y or N
PORPHYRIA BLOOD DISORDER	Y or N	CANCER active or within 1 yr remission*	Y or N
ANGINA PECTORIS	Y or N	CANCER inactive	Y or N
CARDIOVASCULAR DISEASE*	Y or N	CHRONIC CONSTIPATION	Y or N
CONGESTIVE HEART FAILURE*	Y or N	KIDNEY STONES (within 1 year)	Y or N
ACTIVE ALCOHOLIC	Y or N	ONLY ONE FUNCTIONING KIDNEY*	Y or N
POST STROKE	Y or N	KOSHER	Y or N
HEMOPHILIA or LUEKEMIA	Y or N	DIALYSIS/KIDNEY FAILURE/UREMIA*	Y or N
HEART ATTACK within last 10 years	Y or N	LACTOSE INTOLERANT	Y or N

SECTION III

ARTHRITIS	Y or N	GLUTEN ALLERGY	Y or N
BULIMIA, Diagnosed	Y or N	HYPERTHYROIDISM*	Y or N
ASTHMA	Y or N	HYPOTHYROIDISM*	Y or N
CARDIAC ARRHYTHMIA*	Y or N	IRREGULAR HEART BEAT	Y or N
GOUT/High Uric Acid	Y or N	INTESTINAL DISORDERS	Y or N
CARDIOMYOPATHY	Y or N	LYMPHATIC DISEASE*	Y or N
CAROTID ARTERY DISEASE	Y or N	LUPUS*	Y or N
CELIAC DISEASE	Y or N	MITRAL VALVE PROLAPSE	Y or N
CEBERAL SHUNT	Y or N	THROMBOPHLEBITIS	Y or N
COLITIS/IRRITABLE BOWEL DISEASE*	Y or N	PACE MAKER*	Y or N
CORONARY ARTERY DISEASE	Y or N	PARKINSON'S DISEASE	Y or N
CORTISONE THERAPY	Y or N	PHOTOSENSITIVITY/IMMUNOSUPPRESSION*	Y or N
CROHN'S DISEASE*	Y or N	RETINAL DETACHMENT*	Y or N
ENLARGED PROSTATE or		SEVERE ILEITIS	Y or N
DIFFICULTY URINATING	Y or N	SKIN LESIONS*	Y or N
ENDOCARDITIS	Y or N	SPASMS	Y or N
HIGH BLOOD PRESSURE (uncontrolled)*	Y or N	STOMACH SURGERY	
FIBROMYALGIA	Y or N	Ulcer – within 3 years	Y or N
GLAUCOMA	Y or N	Staple – within 2 years	Y or N
HERPES SIMPLEX*	Y or N	Gastric Bypass	Y or N
HIATAL HERNIA	Y or N	VEGETARIAN	Y or N
		WILSONS DISEASE	Y or N
		MULTIPLE SCLEROSIS	Y or N

Please list your Physician's Name, Address, and Phone Number to whom is providing care for you, including your Specialist Physician regarding your above medical conditions:

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 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.

SIGNATURE_____**PRINT NAME**_____**Date / /**____

PARENT GUARDIAN (IF APPLICABLE)_____**PRINT**_____