

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:	Date of Birth:	Age:	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: