True Contouring Solutions

Patient Name: _____ Date: _____

Address: _____ City: _____ St: _____ Zip:_____

Email Address: _____ Ok to send email/text: Yes No

Mobile Phone: _____ Date Of Birth: _____

How did you find out about our body contouring/weightloss program?

_____

Are you currently pregnant, breast feeding, have active cancer, or cholecystitis? Yes No (***If yes, you are not eligible to participate in this program)***

Do you experience any of the following conditions even if they are minor and go away on their own?

___ High Blood Pressure	___ Diabetes	___Headaches	___ Hypoglycemia
___ Cancer	___ Neck Pain	___ Upper Back Pain	___ Thyroid Problems
___Heart Disease	___ Digestive Problems	___ Arthritis	___ Chronic Fatigue
___ Fibromyalgia	___ Numbness	___ Stress/Irritability	___ Sinus/Allergy
___ Hip/Knee Pain	___ Osteoporosis	___ Chronic Inflammation	___ Other

1. Are you currently on any medications and for what health condition?

2. Why do you currently want to lose weight?

3. How long have you struggled with your weight?

4. Have you tried other weight loss plans and if so, what have you tried?

5. What were your results?

6. How long did you keep the weight off?

7. Do you currently take nutritional supplementation? **(if "yes" is the patient taking EFA's? They will need to discontinue EFA's while on this program)**

8. Do you have any other health challenges that you feel is important for us to know about?