

**WeightlossforLife**  
**Application Form**  
*(This information is strictly confidential)*

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**Date:** \_\_\_\_\_

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Hm phone:** \_\_\_\_\_ **Cell:** \_\_\_\_\_ **Fax:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Your Age:** \_\_\_\_\_ **Referred By:** \_\_\_\_\_

**In case of emergency contact:** \_\_\_\_\_

**Primary HP contact info:** \_\_\_\_\_

**While we help you shed any excess weight once and for all, your health is also very important. Therefore please answer the following questions HONESTLY and in as much detail as possible.**

**Current Medical History:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current medications and for what conditions?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**If you know, last blood pressure reading:** \_\_\_\_\_ **Date of this reading:** \_\_\_\_\_

**Previous 5-Year Medical History:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Any comments you may have that could be relevant (particularly of medical/psychological nature):** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List all weight loss programs you have been on?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List all specific or general cravings or hunger pangs you have while on a weight loss program:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# WeightLossforLife

## Application Form Con't

The following are some reactions, which are occasionally experienced by some people when losing weight.

Please print yes or no (or the letter "Y" or "N") where and if application with regards to your previous experience on weight loss programs or diets.

Not Well or Nauseous: \_\_\_ Headaches: \_\_\_ Missing of first period: \_\_\_ Sleeping problems: \_\_\_ Weakness: \_\_\_

Plateaus: \_\_\_ Slight & Temporary hair thinning: \_\_\_

Hunger Pangs: \_\_\_ Lethargy: \_\_\_ Specific or general cravings: \_\_\_ Light Headedness: \_\_\_ Leg cramps: \_\_\_

Any other reactions you might have had:

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*Please leave this section blank until we interview and weigh you.*

*BIA info: Lean % \_\_\_\_\_ Fat % \_\_\_\_\_ Lean lb \_\_\_\_\_ Fat lb \_\_\_\_\_*

*Current weight \_\_\_\_\_ Target goal weight \_\_\_\_\_ Total amount you want to lose \_\_\_\_\_*

*Current size \_\_\_\_\_ Target size \_\_\_\_\_ Realistic time frame in which to lose the weight \_\_\_\_\_*

Once you reach your goal, will you allow us to use your name as a testimonial? \_\_\_\_\_

I believe that the above medical information I have provided is true and correct.

I understand that the WeightlossforLife Program is non-refundable beginning: \_\_\_\_\_.

I also understand that I undertake the WeightlossforLife program entirely at my own risk and that my WeightlossforLife practitioner will endeavor to take all due care.

\_\_\_\_\_  
Beginning on Date

\_\_\_\_\_  
Patient's signature