REVEAL WEIGHT- LOSS

Scarsdale Health & Wellness

First Name: _____MI: _____ Last Name: _____

Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Join our Email List: ☐Yes or ☐No

Date of Birth (MM/DD/YY): _____ Gender: F _____ M _____ Other _____

Height: _____ Desired Weight: _____ Current Weight (OFFICE USE): _____

Do you have Diabetes? ☐No or ☐Yes (List meds);
_____

Do you have high blood pressure? ☐No or ☐Yes (List meds);
_____

Women: Are you currently Pregnant or Breast Feeding? ☐No or ☐Yes

Any Allergies? ☐No or ☐Yes (List);
_____

Medical History: _____

Current Medications: _____

Describe Current Eating Habits in a typical day (e.g. # meals per day, etc.): _____

_____

Client Signature: _____ Date: _____