180 Weight Loss Solutions

Date_____

Name_____

Address_____

City_____ State_____ Zip_____

Home Phone: (_____)_____*Cell (____)_____ *Email_____

Birthdate_____ Age_____ Height___ft___in

Place of Employment _____Occupation_____

Spouse's name _____

Spouse's Place of Employment _____Occupation_____

Children (names and ages)_____

How were you referred to our office? _____

Are you taking any medication? ____NO ____YES

If Yes please list the name of the medication and supplements/vitaminsnand what you are taking it for:

_____

_____

_____

_____

Are you pregnant? ____NO_____YES

Are you breast feeding? _____NO_____YES

Do you have a pacemaker?_____NO _____YES

Do you smoke? _____NO _____YES

Your Primary Care Physician:_____

Address: _____ City_____ Phone_____

Please list any specialist you are currently under the care of:

Name_____ City_____ Phone_____

Name_____ City_____ Phone_____

Name_____ City_____ Phone_____

Has any of the above Doctors recommended you to lose weight? ____NO _____YES

Can we contact the Doctors listed above? _____NO _____YES

Can we share your results with your Doctors? _____NO _____YES

MEDICAL HISTORY

Do you or any family member have/had any of the following? Family "F", personally "√"

_____Brain Fog	_____Hypoglycemia	_____Headache
_____Depression	_____Anemia	_____Poor Sleep/
_____Anxiety	_____Cancer	_____Fatigue
_____Heart Attack	_____High Blood Pressure	_____Arthritis/Joint Pain
_____Diabetes	_____Intestine Problems	_____Mid Back Pain
_____Thyroid Disease	_____Irritable Bowel Syndrome	_____Low Back Pain
_____Gallbladder Disease	_____Shortness of Breath	_____Infertility
_____Kidney Disease	_____High Cholesterol	_____Sexual Dysfunction
_____Stroke		_____Other
_____Gout		

If you marked other, please explain: _____

How long have you struggled with weight or been overweight? _____

Do you currently or have you in the past struggled with the following:

Binge eating? _____NO _____YES Emotional/Stress eating? ____NO ____YES

Have you tried to lose weight in the past? _____NO____YES

If yes please list what you've tried and programs_____

_____

What are your **top 2 values and reasons** you want to lose weight?

1. _____

   _____

2. _____

   _____

What does the weight keep you from, that you LOVE or HAVE to do?_____

_____

GOALS

What is your current weight? _____ Goal weight? _____

Other health, weight, or life goal(s)? _____

When was the last time you were at that weight? _____

Client Signature _____