rejuvenate
MIND-BODY WELLNESS CENTER

lifetime
FAT LOSS CENTERS
A FOCUSED LIFESTYLE CHANGE

Date_____
Name_____
Address_____
City_____ State_____ Zip_____
Telephone-Home (____) _____ Mobile (____)_____Carrier_____
Email_____
DOB (MM/DD/YY) _____ Age_____ Height___ft___in
Occupation_____ Spouse Occupation_____
How were you referred to our office? _____
Are you taking any medication? NO YES Do you wear a pacemaker? NO YES
If Yes please list_____
Are you pregnant? NO YES Are you breast feeding? NO YES

MEDICAL HISTORY

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

_____Heart Attack _____Diabetes* (If yes, is it under control? YES NO) _____Thyroid Disease _____Gallbladder Disease _____Kidney Disease _____Stroke _____Grave's Disease*	_____Gout _____Hypoglycemia _____Anemia _____Cancer _____High Blood Pressure* (If yes, does it require more than 2 medications? YES NO) _____Low Blood Pressure* _____Weak/Compromised Immune system*	_____High Cholesterol _____Headache _____Poor Sleep _____Arthritis _____Shortness of Breath _____Intestinal Problems _____Depression

Primary Care Physician name and address: _____
_____

HISTORY

How long have you been overweight? _____
Have you tried to lose weight in the past? NO YES
If yes please list programs_____
What are your top 2 reasons **WHY** you want to lose weight? _____
_____
What would prevent you from starting our program today? _____
_____
Has your Primary Care Physician recommended you to lose weight? NO YES
Can you attribute your weight gain to anything specific?_____

GOALS

What is your current weight? _____ What is your goal weight? _____
When was the last time you were at that weight? _____
How much have you lost and gained and then lost and gained in the past? _____
On a scale of 1-10, with 10 meaning – I'm fully committed to losing weight and getting healthy, what is your commitment level? _____

CONGRATULATIONS on taking the 1st step in changing your life!