



Melt That Fat Away
(Please Print Clearly)

Your Name:		Referred by:		Today's Date:	
Address:		City:		State: Zip	
Home #:		Work #:		Cell #:	
Email Address:					
Height:		Weight:		Date of Birth:	
				Age: Sex:	
Marital Status:		Are you pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes, how far along?			
How much water do you consume per day?					
Occupation:		How many hours per week do you work?			
Are you currently under the care of a physician? <input type="checkbox"/> No <input type="checkbox"/> Yes, for what reason(s):					
How stressed are you? (On a scale of 1 to 10, where 10 is the worst):					
Have you ever had any health conditions that affected your liver? <input type="checkbox"/> No <input type="checkbox"/> Yes, explain:					
Have you ever had cancer? <input type="checkbox"/> No <input type="checkbox"/> Yes, explain:					
Do you exercise?		<input type="checkbox"/> No <input type="checkbox"/> Yes, how often?		What type?	
Which do you want us to focus on?		<input type="checkbox"/> Abdomen <input type="checkbox"/> Buttocks <input type="checkbox"/> Thighs <input type="checkbox"/> Chest <input type="checkbox"/>			
Arms <input type="checkbox"/> Neck <input type="checkbox"/> Cellulite					
How long have you been overweight?					
How much weight do you want to lose?					
Are you embarrassed about your weight/appearance? <input type="checkbox"/> No <input type="checkbox"/> Yes, explain:					
How important is weight or size reduction to you? (On a scale of 1 to 10, where 10 is the most important)					
Are other members of your family overweight? <input type="checkbox"/> No <input type="checkbox"/> Yes					
Do you feel tired, run down, or out of energy? <input type="checkbox"/> No <input type="checkbox"/> Yes, explain:					

I clearly understand and agree that all services rendered are charged directly to me, and that I am personally responsible for payment.

Your Name (print): _____

Signature: _____ Date: _____

----- DO NOT WRITE BELOW THIS POINT -----

Provider's Notes: