NUTRIMOST DFW

DATE _____

PERSONAL INFORMATION ____Dr. ____ Mr. ____ Mrs. ____ Ms. ____ Miss

Name _____

Address _____

City, State, Zip _____

Telephone (Home) _____ (Mobile) _____ Carrier _____

Date of Birth _____ Age _____ Height _____ Email _____

Occupation _____ Spouse Occupation _____

How were you referred to our office? _____ Which radio station? _____

Have you had surgery in the past? _____

List all medications: _____

Primary Care Physician and Full address: _____

Are you pregnant? _____ How many children? _____ Are you breast feeding? _____

MEDICAL HISTORY

Do you or any family member have/had any of the following? If family member put "F"

___ Depression	___ Epilepsy	___ Headache	___ Low Back Pain
___ Heart Attack	___ Hypoglycemia	___ Neck Pain	___ High Cholesterol
___ Diabetes _____	___ Anemia	___ Poor Sleep	___ Intestine Problems
___ Thyroid Disease _____	___ Cancer	___ Dizziness	___ Shortness of Breath
___ Hysterectomy _____	___ Fibromyalgia	___ Arthritis	___ Stroke
___ Kidney Disease _____	___ High Blood Pressure	___ Mid Back Pain	

HISTORY

Have you tried to lose weight in the past? _____ Has your doctor recommended that you lose weight? _____

_____

_____

_____

GOALS

I. What is your Goal Weight? _____

II. On a scale of 1-10, (10 – Fully committed, I want to start now, 1 – Not interested)

Rate your level of commitment: _____

III. _____

_____

_____