Wellness for Life Weight Loss Program

Client Information

Name : _____ DOB _____

Address : _____ City : _____ State : ____ Zip : _____

E-mail : _____ Contact Phone : _____ Cell Phone : _____

Physician and name of practice (*if known*) : _____

Medications / Supplements / OTC

Medications	Dosage	Directions

Drug / Food / Environmental Allergies : _____

Past Medical History

Illnesses / Diseases : _____

Surgeries : _____

Trauma / Injuries : _____

Hospitalizations : _____

Health Maintence

Date of last physical? _____

Date of last pap smear? _____

Date of last mammogram? _____

Please list any other screenings you have had and when. _____

Are you now, or could you be, pregnant? _____

Use of alcohol and amount : _____

Use of drugs and amount : _____

Caffeine intake and amount : _____

Use of tobacco and amount : _____

Current level of exercise and type : _____

Review of Symptoms

Have you ever experienced problems with any of the following? If yes, please note if they are currently happening or have happened in the past.

Symptoms	Yes / No ?	If yes - Current / Past ?	Symptoms	Yes / No ?	If yes - Current / Past ?
Appetite :			Swelling :		
Fatigue :			Cough Blood :		
Sleep :			Pain in Legs with Exe:rcise :		
Bleeding Gums :			Increased Thirst :		
Heart Complication :			Weight Gain / Loss :		
Shortness of Breath :			Balance :		
Passing Out / Faint :			Nervousness or Anxiety :		
Wheezing :			Jaundice :		
Increased Hunger :			Flank Pain :		
Hot/Cold Sensitivity :			Blood in Urine :		
Hyperactivity :			Anorexia or Bulimia :		
Abnormal Menstrual :			Muscle Weakness :		
Kidney Stones :			Depression :		
Erectile Dysfunction :			Suicidal Thoughts :		
Headache :			Dizzy / Faint :		
Chest Pain :					

Weight Loss History

Please expand on any of the following to give us an idea of your weight loss history.

Use of appetite suppressants, injections or other means of weight loss : _____

Weight loss programs utilized : _____

Club or gym membership : _____

Space below this line is for reviewing physician only – please do not enter any information beyond this point.

Reviewing physician's signature : _____ Date : _____