NEW PATIENT FORM

(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? ❑ No ❑ 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? ❑ No ❑ 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? ❑ No ❑ Yes, explain:		
Have you ever had cancer? ❑ No ❑ Yes, explain:		
Do you exercise? ❑ No ❑ Yes, how often?	What type?	
Which do you want us to focus on? ❑ Abdomen ❑ Buttocks ❑ Thighs ❑ Chest ❑ Arms ❑ Neck ❑ Cellulite		
How long have you been overweight?		
How much weight do you want to lose?		
Are you embarrassed about your weight/appearance? ❑ No ❑ 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? ❑ No ❑ Yes		
Do you feel tired, run down, or out of energy? ❑ No ❑ 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: _____