**Weight Loss New Patient Form**

Dr. Sophie Jacob’s Weight Loss Center

Name: Today’s Date:

Cell#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_

Email:

Address:

Occupation:

**How did you hear about our weight loss program?** *(Please Circle)*

 *Email Facebook Postcard Handout Mail Poster/Sign*

 *Friend Radio TV ad Dr. Sophie Front Desk Weight loss talk*

**Health and Wellness History**

Has your doctor advised you to lose weight?

Do you have any dietary restrictions?

Are you taking any medication?

How often do you exercise?

What type of exercise do you do?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|   | **Daily** | **3 or more per week** | **1-2 times per week** | **1-2 times per month** | **Less than once a month** | **Never** |
| Standing or Walking : |   |   |   |   |   |   |
| Work or Sit at a Desk : |   |   |   |   |   |   |
| Moderate/Heavy labor : |   |   |   |   |   |   |
| Tobacco/Smoke : |   |   |   |   |   |   |
| Alcoholic beverages : |   |   |   |   |   |   |
| Caffeine / Energy drinks: |   |   |   |   |   |   |

**Check ALL areas of treatment that interest you:**

* Weight Loss
* Cleansing and Detoxification
* More Energy
* Cellulite Reduction
* Non-Invasive
Lipo Laser

Do you know that all treatments listed above are 100% safe? 🞎 YES 🞎 NO

Have you ever used any of the above treatments before? 🞎 YES 🞎 NO

What do you consider to be your ideal weight?

How much weight do you want to lose?

When was the last time you were at your goal weight?

*~ Turn Over To Complete ~*

How many times a year do you diet?

What is stopping you from losing weight on your own?

List of surgeries?

Does your weight problem make you physically uncomfortable? 🞎 YES 🞎 NO

Does your weight problem cause you physical pain? 🞎 YES 🞎 NO

Are you embarrassed by your excessive weight? 🞎 YES 🞎 NO

Do you binge eat? 🞎 YES 🞎 NO

Do you suffer from uncontrollable cravings? 🞎 YES 🞎 NO

Do you eat because of your emotions? 🞎 YES 🞎 NO

Do you eat between meals? 🞎 YES 🞎 NO If yes, what do you eat?

Do you feel that your eating behaviors are normal? 🞎 YES 🞎 NO

How often do you feel tired, or out of energy?

How fast do you want to be slim, trim, and fit?

Is Successful weight loss a top priority? 🞎 YES 🞎 NO

**Check the following conditions you want help with or more information on:**

* Cleansing
* Cellulite
* Hormone Balance
* Neuropathy
* Pain Relief
* Quit Smoking
* Weight Loss
* Thyroid

**What is the MOST important element in deciding to use our services?**

Effectiveness: “My results are my top priority”

Time: “I want results quickly”

*Circle only ONE*

*of the four answers*

Service: “I need extra support along the way”

Affordability: “I need this to be affordable”

🗹 **I understand that my entire patient history will remain completely confidential and will not be released without express written consent from me.**

Signature: Date:

*For Doctors Use Only:*

**Current Weight** **BMI** \_\_\_\_\_\_\_ \_

Age Height **ph**\_\_\_\_\_\_\_\_\_\_\_ **FAT%**\_\_\_\_\_\_\_\_\_\_\_

Kids # Pregnant? Yes / No Spouse / Other Name

**Measurements**

Back: Hips: Mid-Abdomen (Belly Button):

Waist: Left Thigh: Right Thigh: