True Weight Solutions

Patient Name: ____ Date: _____________

Address: ____ City: __________ St: ______ Zip: ____________

Email Address: _______________________________________ Ok to send email: Yes No

Phone: _______________ Date Of Birth: _______________

How did you find out about our weight loss program? ____

Are you currently pregnant, breast feeding, have active cancer, or cholecystitis? Yes No (***If yes, you are not eligible to participate in this program)***

Do you experience any of the following conditions even if they are minor and go away on their own?

___ High Blood Pressure	___ Diabetes	___Headaches	___ Hypoglycemia
___ Cancer	___ Neck Pain	___ Upper Back Pain	___ Thyroid Problems
___Heart Disease	___ Digestive Problems	___ Arthritis	___ Chronic Fatigue
___ Fibromyalgia	___ Numbness	___ Stress/Irritability	___ Sinus/Allergy
___ Hip/Knee Pain	___ Osteoporosis	___ Chronic Inflammation	___ Other

1. Are you currently on any medications and for what health condition?

2. Why do you currently want to lose weight?

3. How long have you struggled with your weight?

4. Have you tried other weight loss plans and if so, what have you tried?

5. What were your results?

6. How long did you keep the weight off?

7. Do you currently take nutritional supplementation? **(if "yes" is the patient taking EFA's? They will need to discontinue EFA's while on this program)**

8. Do you have any other health challenges that you feel is important for us to know about?

True Weight Solutions

Patient Name: ____ Date:______________

Patient's Height in Inches: _______________ Patient's Age: _______________

Patient's Current Weight: _______________ Patient's Goal Weight: _______________

Calculate Patient's Current BMI: (Weight in Pounds x 703) ÷ (height in inches x height in inches)

Patient's Current BMI: _______________ Patient's Goal BMI: _______________

Initial Visit Date: _______________

Body Inches Measurement Chart

	Start	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Total Lost

Neck								
Shoulder								
Chest								
Bicep								
Waist								
Hips								
UpperThigh								
Calf								

Start Date: _______________

Weight: _________ BP: _______/________ Pounds Lost: _________ Inches Lost: _________ BMI:_________

Week 1 Date: _______________

Weight: _________ BP: _______/________ Pounds Lost: _________ Inches Lost: _________ BMI:_________

Challenges/Concerns and Recommendations: ____

____

____

Week 2 Date: _______________

Weight: _________ BP: _______/________ Pounds Lost: _________ Inches Lost: _________ BMI:_________

Challenges/Concerns and Recommendations: ____

____

____

Week 3 Date: _______________

Weight: _________ BP: _______/________ Pounds Lost: _________ Inches Lost: _________ BMI:_________

Challenges/Concerns and Recommendations: ____

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____

Week 4 Date: ________________

Weight: __________ BP: ________/_________ Pounds Lost: __________ Inches Lost: __________ BMI:__________

Challenges/Concerns and Recommendations: ____

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Week 5 Date: ________________

Weight: __________ BP: ________/_________ Pounds Lost: __________ Inches Lost: __________ BMI:__________

Challenges/Concerns and Recommendations: ____

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Week 6 Date: ________________

Weight: __________ BP: ________/_________ Pounds Lost: __________ Inches Lost: __________ BMI:__________

Challenges/Concerns and Recommendations: ____

____

____

Week 7 Date: ________________

Weight: __________ BP: ________/_________ Pounds Lost: __________ Inches Lost: __________ BMI:__________

Challenges/Concerns and Recommendations: ____

____

____

Week 8 Date: ________________

Weight: __________ BP: ________/_________ Pounds Lost: __________ Inches Lost: __________ BMI:__________

Challenges/Concerns and Recommendations: ____

____

____

Total Pound Lost: ________________ Total Inches Lost: ________________

Ending BMI: ________________ Ending BP:_______________