

# Health History

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Best Phone to Contact: \_\_\_\_\_ Alternative Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

DOB: \_\_\_\_\_ Occupation: \_\_\_\_\_

Referred By: \_\_\_\_\_

Family – Spouse/Partner, Kids, Creatures \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Do you have a pacemaker?  yes  no

Are you pregnant or nursing?  yes  no (The protocol is not acceptable for women who are pregnant or nursing.)

Have you ever been diagnosed with alcoholism?  yes  no (Please talk to your Weight Loss Consultant for alternatives.)

List all medications and supplements (i.e., antibiotics, aspirin, etc.). Please bring supplements to your first appointment.

Name:		Purpose:		Dose/How Often:	
Name:		Purpose:		Dose/How Often:	
Name:		Purpose:		Dose/How Often:	
Name:		Purpose:		Dose/How Often:	
Name:		Purpose:		Dose/How Often:	

Please check off any of the following conditions or symptoms which apply to you now or in the past:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Anxiety                       | <input type="checkbox"/> Gall Bladder Issues | <input type="checkbox"/> Low Blood Sugar       |
| <input type="checkbox"/> Chills                        | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Night Sweats          |
| <input type="checkbox"/> Crohn's, Colitis, or IBS      | <input type="checkbox"/> Heavy Sleep         | <input type="checkbox"/> Poor Coordination     |
| <input type="checkbox"/> Depression                    | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rash                  |
| <input type="checkbox"/> Dry Skin                      | <input type="checkbox"/> High Blood Sugar    | <input type="checkbox"/> Sensitive Abdomen     |
| <input type="checkbox"/> Eczema / Psoriasis            | <input type="checkbox"/> Hives               | <input type="checkbox"/> Sleepy During The Day |
| <input type="checkbox"/> Fatigue                       | <input type="checkbox"/> Kidney Issues       | <input type="checkbox"/> Sweat Easily          |
| <input type="checkbox"/> Fevers                        | <input type="checkbox"/> Localized Weakness  | <input type="checkbox"/> Tremors               |
| <input type="checkbox"/> Fibroids (Breasts or Uterine) | <input type="checkbox"/> Low Blood Pressure  | <input type="checkbox"/> Vertigo               |

If you checked Kidney or Gall Bladder or have an "other" condition, please explain. \_\_\_\_\_

Please list any allergies \_\_\_\_\_

**Past Medical History (please include dates)**

**Childhood Diseases?**

**Please List Surgeries:** \_\_\_\_\_

**Accidents / Significant Traumas:** \_\_\_\_\_

**Other Injuries/Broken Bones?** \_\_\_\_\_

**Are you currently, or have you at any time within the last 12 months been under the care of a physician? If yes, explain:**

\_\_\_\_\_  
\_\_\_\_\_

**Daily Eating Habits (List Typical Food/Beverage and Time):**

**Breakfast:**

**Lunch:**

**Dinner:**

**Snacks:**

**Do you currently smoke?**  yes  no **How many cigarettes / cigars a day?** \_\_\_\_\_

**Do you currently chew tobacco?**  yes  no

**Do you crave or eat...** \_\_\_\_\_ **Sugar?** \_\_\_\_\_ **Salt?** \_\_\_\_\_ **Chocolate?** \_\_\_\_\_

**Caffeine use: (amount per day/ week, include coffee, tea, colas, Excedrin, etc.)** \_\_\_\_\_

\_\_\_\_\_

**List Physical Exercise or Other Body Movement Program**

**Activity:** \_\_\_\_\_ **How Often:** \_\_\_\_\_

**Activity:** \_\_\_\_\_ **How Often:** \_\_\_\_\_

**Activity:** \_\_\_\_\_ **How Often:** \_\_\_\_\_

**How much water do you drink each day?** \_\_\_\_\_ **How much weight do you wish to lose?** \_\_\_\_\_

I have completed this health form to the best of my knowledge. I understand that 1-2-3 Weight Loss Clinic is a coaching clinic for weight loss and is not providing medical advice. Any information exchange during a coaching session is confidential and only used to provide you with the best service.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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## Medical Disclaimer

The packet provides weight loss management information and is intended only to assist users in their personal weight loss efforts. 1-2-3 Weight Loss Clinic is not a medical organization and our staff will not give you medical advice or diagnosis. Nothing contained in this packet should be construed as medical advice or diagnosis. The information generated by us should not be interpreted as a substitute for physician consultation, evaluation, or treatment.

You are urged and advised to seek the advice of a physician before beginning any weight loss effort or regimen. This information is not meant to replace the advice of any physician. Do not rely upon any information to replace the consultations or advice received by qualified health professional regarding your own specific situation. Any information provided by 1-2-3 Weight Loss Clinic should NEVER be construed as medical advice.

If you have any question in your mind regarding any lingering health concern, you should seek medical assistance. If you are not satisfied with the advice being rendered by your current physician, you always have the right to obtain another medical opinion. We are not physicians or doctors at 1-2-3 Weight Loss Clinic. We are weight loss consultants.

It is important for you to understand the 1-2-3 Weight Loss Clinic is staffed entirely by weight loss consultants who are neither physicians nor pharmacists.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Client Agreement

I, \_\_\_\_\_, have chosen to participate in the 1-2-3 Weight Loss Clinic for weight loss, which includes diet, behavior changes, and supplements. I am aware that results may vary and are not guaranteed. As with any diet, there are possible risks of fatigue, mild headaches, etc. I agree that I have been counseled on a specific weight loss program for me with diet and supplements to attain my targeted weight loss. I must follow the program to achieve the desired results. I have read and understand all disclosures provided by 1-2-3 Weight Loss Clinic.

This agreement will begin on \_\_\_\_\_ and end on \_\_\_\_\_.

Once you sign this client agreement with 1-2-3 Weight Loss Clinic, no refund or part refund will be rendered.

If your program includes appointments with your consultant, kindly give 24 hours notice if you need to cancel or reschedule. If you fail to do so, a \$25 charge will be added to your account.

Do not sign this contract before you read this entire agreement, because all terms and agreements are a part of this agreement. The Client acknowledges that they have been given the following information: (a) that this document is a contract and will become a legally binding contract upon its acceptance by 1-2-3 Weight Loss Clinic; (b) the terms and conditions of this contract; (c) that the Client assumes any and all risks involved in the participation of the weight loss protocol; and (d) that you have receive a completed copy of this agreement and agree to be bound thereby.

The Client understands that he/she:

- ✕ makes a full commitment to implement the 1-2-3 Weight Loss Protocol;
- ✕ will keep a daily food log with notes regarding emotions, exercise, etc.;
- ✕ take full responsibility for his/her decisions and actions; and
- ✕ will need to change eating habits and/or lifestyle to maintain the weight loss.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Consultant Signature: \_\_\_\_\_ Date: \_\_\_\_\_