re:vitalize
weight loss & wellness

PERSONAL INFORMATION

Date:________________

Dr.__ Mr.__ Mrs.__ Ms. __ Miss.__ Name: ____

Address ______________________________________ City, State, Zip__________________________

Telephone ___________________ Email____

Date of Birth_____/_____/________ Age:___________ Current Weight:___________________ Height:_______________

Occupation______________________________ Spouse Occupation______________________________

Employed By_________________________________ **Do you have a HSA or FSA?** ☐ Y ☐ N

HOW WERE YOU REFERRED TO OUR OFFICE? (Choose more than one if applicable)

☐ Radio: Which Station? ____________________

☐ Television: ____________________

☐ Friend or family: ____________________

☐ Newspaper: ____________________

☐ Physician: ____________________

☐ Internet Search

☐ Facebook / Instagram Ad

☐ Other: ____________________

MEDICAL HISTORY

Do you have/had any of the following?

☐ Depression
☐ Heart Attack
☐ Diabetes
☐ Thyroid Disease
☐ Kidney Disease
☐ Epilepsy
☐ Organ Transplant
☐ Stroke
☐ Hypoglycemia
☐ Anemia
☐ Cancer
☐ High Blood Pressure
☐ Intestine Problems
☐ Gallbladder Disease
☐ Headache
☐ Neck Pain
☐ Poor Sleep
☐ Dizziness
☐ Arthritis
☐ High Cholesterol
☐ Shortness of Breath
☐ Gout
☐ Mid Back Pain
☐ Low Back Pain
☐ Carpal Tunnel

How many children do you have?______ Are you pregnant or nursing? ☐ Y ☐ N Do you smoke? ☐ Y ☐ N Drink? ☐ Y ☐ N

List any major surgeries you have had: ____

____

Known allergies: ____________________________ List any medications you're taking: ____________________

____

How many times per week do you eat out? _____________ Average hours of sleep per night? ________________

Do you have a solid support system at home? ☐ Y ☐ N ☐ Sometimes Energy level on a scale of 1-10?__________

HISTORY

How long have you been overweight? ____

What have you done to lose weight in the past?____

What are your top reasons why you want to lose weight and get healthy? ____________________________

____

Can you attribute your weight gain to anything specifically? ______________________________________

Has your doctor recommended you to lose weight? ☐ Y ☐ N

GOALS

What is your goal weight? ____________________ When was the last time you were at that weight?_____________

Which aspects of the re:vitalize program interest you most?

☐ Focus on fixing the metabolism

☐ Doctor supervised

☐ Guaranteed results

☐ Proven, science & technology-driven approach

☐ Real, whole food (no bars, shakes, pre-packaged foods)

☐ Holistic approach (no shots, stimulants, hormones)

☐ Board-certified nutritionists and expert coaches

☐ Long-term support and ongoing accountability

☐ Fast results

☐ Other: ____________________

On a scale of 1-10, how ready are you to make meaningful lifestyle changes and get healthy? __________