Diet by Design **Date_____**

Consultation Information Sheet
Personal Information

Last Name		First Name	Middle Initial
Date of Birth	Sex	Weight /Height	Age
Address			
City		State	Zip Code
Home Phone		Cell Phone	
Occupation		Email Address	

Allergies	**Cardiac**	**Surgery**
O None O Unknown Medical Allergies: _____ _____ _____ _____ _____ _____ _____ _____ _____	O None O Unknown O Angina O Arrhythmia O Cardiomyopathy O CHF O Congenital O Implanted Defib O MI Other_____ _____ _____	O None O Unknown O Abdominal O Heart O Lung O Neurological Other_____ _____ _____ _____ _____ _____
Chronic Illnesses		
O None O Asthma O Bleeding Disorder O Cancer-Any O Cyst-Any O CVA / TIA O Diabetic O Type 1 O Type 2	O Dialysis/Renal O Gall Bladder O Gastrointestinal O Gout O Headaches O Hepatitis O HIV + O Hypertension O Paralysis	O Psychological O Seizures O Substance Abuse O TB O Unknown Other_____ _____ _____ _____

Revised By SMS 09/2012

Diet by Design **Date_____**

Current Medications AND Medical Conditions in the Past Year

O None O Unknown _____

_____

_____

_____

_____

_____

Past Medical History
Emergency Contact Information

Primary Physician	Physician Phone Number
Primary Contact Name & Relationship	Primary Contact Phone Numbers
Previous Methods of Weight Loss _____	Results
How did you hear about us? _____	

Please Select Program Options of Interest

O HCG Injections
O Hypnosis
O HCG Oral Drops
O Non-HCG Weight Loss
O Fitness
O One on One Weight Loss Counseling
O Group Weight Loss Counseling
OHCG Nasal Spray
O Slim Shot Injections
O Prescription Weight Loss Aids
O B12 Injections
O Other _____
_____

_____ _____
Patient Signature Staff Representative Signature

_____ _____
Date Date

Revised By SMS 09/2012