Name _____ **Date:** _____

When did you begin to gain weight? ◯ **after an employment change** ◯ **during a stressful period**

◯ **after childbirth** ◯ **After marriage** ◯ **Other**

How long have you been overweight? ◯ **year or less** ◯ **2-5 years** ◯ **6-10 years** ◯ **10 years**

What is your cause of your weight problem? ◯ **Frequently overeat** ◯ **Enjoy fatting foods**
◯ **Lack of activity** ◯ **Heredity** ◯ **other** _____

How many meals you eat daily? _____
How many serious attempts have you made at dieting? _____
What is the longest you been able to stick to a diet? ◯ **0-1 month** ◯ **2-6 months** ◯ **7-12 months** ◯ **over 12 months**
What other reduction methods have you tried? ◯ **Weight watchers** ◯ **Diet Books** ◯ **Physician** ◯ **Do it yourself**
◯ **Other** ____
_____ **What is the nature of your difficulties while dieting?** _____
Are you under a physician's care? ◯ **Yes** ◯ **No**
Have you been advised by your physician to lose weight? ◯ **Yes** ◯ **No**
Do you have any physical problems that you know are associated with your weight? ◯ **Yes** ◯ **No**
Why do you want to lose weight? ◯ **Appearance** ◯ **Special Occasion** ◯ **Health reasons**
◯ **To please family/friends** ◯ **Other** _____
Has your significant other encourage you to lose weight? ◯ **Yes** ◯ **No**
How important is it for you to lose weight? ◯ **Extremely important** ◯ **Very important**
◯ **Important** ◯ **Not very important**
Do you work? ◯ **Yes** ◯ **No**
◯ **Full time** ◯ **Part time** ◯ **Occupation** _____

Number of children_____**Ages** _____
Are any of your children overweight? ◯ **Yes** ◯ **No**

What is your current weight?_____**What was your highest weight in the last 5 years?** ____
What was your lowers weight in the last 5 years?_____**What is your goal weight?** __
Do you have sulfa allergy? ◯ **Yes** ◯ **No**

Please explain the reason why you want to take the steps necessary to lose weight:

_____
_____
_____
_____

I wish to apply for admission to the Ideal Health Weight Loss Program. I realize that admission cannot be guaranteed, and will depend on results of a comprehensive medical evaluation I am aware of the financial and time commitments involved, and feel I can complete the program.

_____ _____
Signature **Date**

WEIGHT LOSS PROTOCOL & CONSENT
IDEAL HEALTH MEDICAL CENTER

I, the undersigned as a client of the medically supervised rapid weight loss program understand that when the exact protocol is followed, I can expect to achieve satisfactory weight loss expectations. I do not have any medical conditions that preclude my involvement with a strict diet program and I have a regular primary care physician. The exact protocol consists of the following criteria:

- ✓ Keeping a daily weight log during all phases of the program
- ✓ Keeping a daily log of what foods I've consumed on my Induction Phase worksheets
- ✓ Weekly meetings with my weight management professional.
- ✓ Taking my injections consistently once a day during the Phase I and II
- ✓ Coming to the office for my weekly M.I.C. injection
- ✓ Following the diet as it states in my packet and sticking to the foods on my list.

I understand the above protocol and that there are no guarantees of specific amounts of weight loss and that individuals successes may vary.

Signature: _____ Date:_____

PERSONAL MEDICAL HISTORY

FIBROIDS	Y/N	GALLSTONES	Y/N
CARDIAC DISEASE	Y/N	THYROID DISORDER	Y/N
DIURETICS	Y/N	TYPE 1 DIABETES	Y/N
RHEUMATISM	Y/N	HYPERLIPIDEMIA	Y/N
GOUT	Y/N	HYPERTENSION	Y/N
PEPTIC ULCERS	Y/N	GI PROBLEMS	Y/N
PSORIASIS	Y/N	VARICOSE VEINS	Y/N
HYSTERECTOMY	Y/N	IRREGULAR PERIODS	Y/N

Please explain any additional pertinent medical history:

_____

List all medications being taken [Include vitamins and OTC meds]

_____

EXERCISE HISTORY

CARDIOVASCULAR	Y/N	1-3 days a week	5-7 days a week
HEAVY WEIGHTS	Y/N	1-3 days a week	5-7 days a week
LIGHT WEIGHTS	Y/N	1-3 days a week	5-7 days a week
NONE	Y/N		

Have you had and surgical procedures for weight management? Y/N
1. Are you a Vegetarian? Y/N
2. If yes, what type: Please check which one
Vegan (plant only) __ Lactovegetarian (plant and dairy) _____
Ovalactovegetarian (Plant, Dairy and egg) __ Fruitarian (Fruits, nuts, honey, vegetables) __
3. Do you have any food allergies/sensitivities? Y/N _____
Starting Weight_____ Starting Body Fat Comp____ BP _____ Goal Weight _____