

WeightLossforLife
Application Form
Leslie Axelrod, ND, L.Ac.
(This information is strictly confidential)

Date: _____

Last Name: _____ First Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Hm phone: _____ Cell: _____ Fax: _____ Email: _____

Your Age: _____ Referred By: _____

In case of emergency contact: _____

Primary HP contact info: _____

While we help you shed any excess weight once and for all, your health is also very important. Therefore please answer the following questions HONESTLY and in as much detail as possible.

Current Medical History: _____

Current medications and for what conditions? _____

If you know, last blood pressure reading: _____ **Date of this reading:** _____

Previous 5-Year Medical History: _____

Any comments you may have that could be relevant (particularly of medical/psychological nature):

List all weight loss programs you have been on? _____

List all specific or general cravings or hunger pangs you have while on a weight loss program:

WeightLossforLife Application Form Con't

The following are some reactions, which are occasionally experienced by some people when losing weight.

Please print yes or no (or the letter "Y" or "N") where and if applicable with regards to your previous experience on weight loss programs or diets.

Not Well or Nauseous: ___ Headaches: ___ Missing of first period: ___ Sleeping problems: ___
Weakness: ___

Plateaus: ___ Slight & Temporary hair thinning: ___

Hunger Pangs: ___ Lethargy: ___ Specific or general cravings: ___ Light Headedness: ___ Leg cramps: ___

Any other reactions you might have had:

Please leave this section blank until we interview and weigh you.

Current weight ___ Target goal weight _____ Total amount you want to lose _____

Current size _____ Target size _____

Realistic time frame in which to lose the weight _____

Once you reach your goal, will you allow us to use your name as a testimonial? ___

I believe that the above medical information I have provided is true and correct.

I understand that WeightlossforLife Program is non-refundable beginning: _____:

I also understand that I undertake the WeightlossforLife program entirely at my own risk and that my WeightlossforLife practitioner will endeavor to take all due care.

I understand that my visits with Dr. Axelrod will directly address my weight loss program and there will be an additional fee and appointment time needed to discuss other health concerns.

Beginning on Date

Patient's signature