Dr. Augello's Health & Body Makeover

Name: _____ Date: ____/____/_____

Date of Birth: ____/____/_____ Age: _____ Sex: _____ Ht:_____Wt:_____

Address: _____

City:_____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____Marital Status: S___M___D___W___

Occupation: _____Work Status: Full Time___Part Time__

Family Doctor:_____

How did you hear about us?(Please be specific)

_____

What is you current weight?_____ What do you think your ideal weight is?_____
How long has it been since you were at that weight?_____

Do you have diabetes? Yes____ No____ If yes, are you Type 1_____ or Type 2?_____
If you are Type 2, when did you become a type 2 diabetic?_____

Have you ever had any weight loss surgeries or procedures performed? Yes___No_____
If yes, please describe.

_____

Are you pregnant or trying to become pregnant? Yes____No____ Nursing? Yes___No___

List all medications you take **and the reason why**. _____

_____

Do you take supplements/vitamins? Yes____No____If yes, please list:

_____

Do you have any dietary restrictions? Yes___ No___ If yes, please explain:_____

_____

Do you exercise? Yes___No___ If yes, what do you, how often, and and for how long?

_____

(Please turn over)

Have you ever tried to lose weight before? If yes, list the last two things you tried and the result. _____

_____

Do you have any neck or back pain? Yes____No____If yes, describe:

_____

Do you have any physical conditions that would restrict you from performing low impact exercises? _____

Circle any symptoms or conditions that you are experiencing or have a concern about.

Weight Gain	Muscle Ache	Joint Pain	Immune Deficiency
Mental Clarity	Fitness	Fatigue	Sleep Disturbances
Thyroid	Leaky Gut	Headache	Gas/ Bloating
Bad Breath	Arthritis	Anti-Aging	Chemical Sensitivity
Exhaustion	Infertility	Acne/ Skin Rash	Depression
Libido	Over Eating	Food Cravings	Menstrual Irregularities
Fibromyalgia	Digestion	Candida	Chronic Fatigue Syndrome

Other:_____

Does your family support your weight loss efforts? Yes____ No____

Are you under stress? Yes____ No____ If yes, please explain:_____

_____

Has being overweight caused you emotional pain? Yes___ No___ If yes, please explain:

_____

Did you know we offer coaching support 24 hours a day, 7 days a week? Yes___No___

Did you know we offer health and weight loss maintenance programs? Yes___No___

Did you know we continue to support you **after** you lose your weight? Yes___ No___

I understand that my entire patient file will remain completely confidential unless I have given a release in writing.

Sgnature_____Date_____