

Dr. Augello's Health and Body Makeover LLC

1578 Easton Ave. Bethlehem, PA 18017

Intake Form

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 your 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 currently on or have been on weight loss injections? 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 exercise? Yes ___ No___ If yes, what do you, how often, and for how long?

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	Neuropathy
Mental Clarity	Fitness	Fatigue	Sleep Disturbances	Asthma
Thyroid	Leaky Gut	Headache	Gas/Bloating	Sleep Apnea
Bad Breath	Arthritis	Anti-Aging	Heart Burn	High Blood Pressure
Exhaustion	Infertility	Acne/Skin Rash	Depression	High Cholesterol
Libido	Over-Eating	Food Cravings	Menstrual Irregularities	Allergies
Fibromyalgia	Digestion	Candida	Chronic Fatigue Syndrome	PCOS
Gerd	Fatty Liver	Kidney Failure	Hormone Imbalance	Gall/Kidney Stones

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 offer interest free financing after a 50% deposit is made? Yes ___ No ___

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

Signature _____ Date _____

Are you currently on blood thinners Yes No

Do you have a heart condition? Yes No
If yes, explain _____

Have you had cancer within the last five years? Yes No
If yes, explain _____

Do you have any varicose veins? Yes No
If yes, explain _____

Do you have epilepsy? Yes No

Do you or have you ever had seizures? Yes No

*Do you have a pacemaker? Yes No

*Do you have a defibrillator? Yes No

If you have or have had any of the above conditions in the past, please take the following papers to your family practitioner for the okay to receive detoxifying body wraps and other services from our office.

*We use True Tesla Electro Muscular Stimulator for the Neuropathy Program.

WAIVER

I, the undersigned, have read, understood and have answered the above health and medical survey questions fully and truthfully. I am aware of my responsibility to consult with my personal physician regarding clearance to engage in a Nutritional and Health Program. I do hereby intend to be legally bound for myself and waive release of any and all rights and claims for damages, as well as the program creators themselves or anyone in connection with them for any and all injuries suffered while following the Nutrition and Health Program provided to me.

Signature _____ Date _____

If patient is under 18 years of age:
Guardian signature _____ Date _____