**French Town Oasis**

**Melt That Fat Away**

(Please Print Clearly)

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| Your Name: Referred by: Today’s Date:  |
| Address: City: State: Zip: |
| Home #: Work #: Cell #:  |
| Email Address:  |
| Height: Weight: Date of Birth: Age: Sex:  |
| Marital Status: Are you pregnant? ❏ No ❏ Yes, how far along?  |
| How much water do you consume per day? |
| Occupation: How many hours per week do you work? |
| Are you currently under the care of a physician? ❏ No ❏ Yes, for what reason(s): |
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| How stressed are you? (On a scale of 1 to 10, where 10 is the worst): |
| Have you ever had any health conditions that affected your liver? ❏ No ❏ Yes, explain: |
| Have you ever had cancer? ❏ No ❏ Yes, explain: |
| Do you exercise? ❏ No ❏ Yes, how often? What type? |
| Which do you want us to focus on? ❏ Abdomen ❏ Buttocks ❏ Thighs ❏ Chest ❏ Arms ❏ Neck ❏ Cellulite |

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| How long have you been overweight?  |
| How much weight do you want to lose?  |
| Are you embarrassed about your weight/appearance? ❏ No ❏ Yes, explain: |
| How important is weight or size reduction to you? (On a scale of 1 to 10, where 10 is the most important)  |
| Are other members of your family overweight? ❏ No ❏ Yes |
| Do you feel tired, run down, or out of energy? ❏ No ❏ Yes, explain: |

I clearly understand and agree that all services rendered are charged directly to me, and that I am personally responsible for payment.

Your Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

---------------------------------------------- DO NOT WRITE BELOW THIS POINT ----------------------------------------------

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| Provider’s Notes: |
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