Medical Weight Loss Transformation Information

Please fill out the following information:

Name_____ **Date**_____

Current Weight: _____

Target Weight: _____

Why do you want to achieve your target weight?(Please be Detailed)

How long has this been your goal? _____

Who else does this goal affect? _____

Are you ready for a change and need help? Yes / No

What have you tried in the past to lose weight? (please list all starting with current or most recent)

1. _____
2. _____
3. _____
4. _____
5. _____

If accepted for our program, will you take prescribed medications and follow all protocols and advice given to ensure your results? Yes/No

Signature: _____

Date: _____