Healthy Way Initial Intake

Name:
Address:
City, State, Zip:
Phone Number:
E-mail Address:
Birth Date: **Age:**
Occupation:
Doctor's Name:
Doctor's Phone:

How did you hear about us?

- ☐ **Friend**
- ☐ **Radio**
- ☐ **Print Advertising**
- ☐ **Former Client**
- ☐ **Doctor Referral**
- ☐ **Facebook**
- ☐ **Instagram**
- ☐ **Google**
- ☐ **Other:**

When did you begin to gain excess weight?

What factors do you feel have contributed to your weight gain?

What other methods of losing weight have you tried? Please specify:

When were you most satisfied with your weight?

Why is it important for you to lose weight now?

What foods or situations do you find problematic?

Do you have a support system that will aid you in your weight loss?

What is your current form of exercise?

Are you willing to follow through with a maintenance program?

Are you pregnant? Yes ☐ No ☐
Are you a nursing mother? Yes ☐ No ☐
Do you have diabetes? Yes ☐ No ☐
Diet controlled? Yes ☐ No ☐
Insulin shots ☐ ***Oral Diabetic Medication?**
Are you hypoglycemic? Yes ☐ No ☐
***Have you had cancer?** Yes ☐ No ☐
***Do you have kidney disease?** Yes ☐ No ☐
***Have you had kidney stones? How long ago?**

***Have you suffered from anorexia or bulimia?** Yes ☐ No ☐
***Have you had gallstones?** Yes ☐ No ☐ **How long ago?**

Have you had any surgical procedures? Yes ☐ No ☐
Please explain:
Do you have any food allergies?
***Are you 50 pounds or more overweight?** Yes ☐ No ☐
Do you have any other medical problems for which you are receiving treatment?

Has a doctor recommended you lose weight? Yes ☐ No ☐
***Do you have high blood pressure?** Yes ☐ No ☐
***Do you take hypertensive medication?** Yes ☐ No ☐
Please list any medications you are taking at this time:

Do you have any gastrointestinal problems or constipation? Yes ☐ No ☐
***Do you have heart disease?** Yes ☐ No ☐
Do you have a history of headache? Yes ☐ No ☐
Do you have any other health concerns? Please List:

Please see other side of this paper to take our sugar sensitivity test.

Office Use Only

Height: _____ **Initial Weight:** _____

Goal Range: _____

*The Healthy Way will obtain a medical prescription from your doctor, in some cases the program may be tax deductible.

Are You Sugar Sensitive?

Do you experience:	**Occasionally to Frequently**	**Rarely to not at all**
1. Thinking of food (sense of hunger) more than you feel comfortable with*	☐	☐
2. Light-headedness*	☐	☐
3. Cravings for sweets or carbohydrates*	☐	☐
4. Drop in energy (body feels like "lead bricks"), especially mid-day	☐	☐
5. Tunnel or blurred vision*	☐	☐
6. Headache*	☐	☐
7. Difficulty in concentration*	☐	☐
8. Indigestion or gas*	☐	☐
9. Rapid weight gain or difficulty controlling weight*	☐	☐
10. Out-of-control or compulsive behavior with food, especially sweets or starches*	☐	☐
11. Mood swings/depression*	☐	☐
12. High cholesterol or triglycerides readings*	☐	☐
13. Hunger between meals or snacking late at night	☐	☐
14. Cold extremities	☐	☐
15. Consumption of processed or packaged foods	☐	☐
16. No breakfast and/or irregular meals	☐	☐
17. Drink 2 or more cups of coffee, tea, sodas or artificially sweetened beverages per day	☐	☐
18. Alcohol consumption more than once per week	☐	☐
19. Snacks generally consist of fruit, crackers, chips, cookies or candy	☐	☐
20. PMS/menopausal symptoms	☐	☐
21. Take birth control pills or female hormone replacement therapy	☐	☐
22. Bread, pasta, other starch, fruit/sweets are usually included in one or more meals per day	☐	☐
23. Smoke one or more packs of cigarettes per day	☐	☐
24. Experience stress at both home and work	☐	☐

Score:

TOTALS

These are all signs and symptoms of fluctuating blood sugar. A score of 4 or more classic symptoms (*) or an overall score of 10 or more "frequent" items suggests that you are a candidate for the Healthy Way Metabolic Adjustment Program. This program focuses on the revolutionary concept of blood sugar stabilization and hormonal balance to create long term success. We have the answers for you!!

Privacy Policy: We do not share your personal information with any other organizations or individuals. We keep all information you provide to us no matter how or why you provide it completely confidential and use it only for the purpose that you intended. We do not provide any information about our subscribers, customers, or affiliates to any third party except of course in the unusual event should we be required to do so by law.

Release Form: In consideration of your accepting me into the healthy way weight management program, henceforth referred as the program I for myself, my personal representatives, heirs and next of kin hereby release and discard the healthy way it's owners, directors, agents and employees from all liability to me, my personal representatives and heirs for any and all loss, damage or any claims or demand on account of personal injury or death arising out of participation in the program. I am fully aware of the risks inherent in participating in any weight loss program, especially for those who must lose fifty (50) pounds or more to reach their ideal weight. I hereby elect to voluntarily participate in the program and voluntarily assume all risks of loss and injury which I may sustain as a result of my participation in the program. I attest that I have no undisclosed ailments, physical or healthy conditions that would increase the risk of loss or injury to me from participation in the program. In the event of a medical condition the Healthy Way will contact your physician to obtain prescription for care. If I wish to lose fifty (50) pounds or more to reach my ideal weight or if I have a medical condition not being supervised by medical personnel I the undersigned take full responsibility for any health and do so without obtaining medical approval and hereby fully release The Healthy Way, Inc.

I have answered the above information to the best of my knowledge.

Signature:

Date: