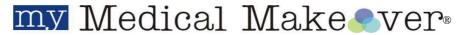
Today's Date:	,	<i>'</i>	/



## Total Body Wellness

Weight-loss Patient Information



## Total Body Wellness

Weight-loss Patient Information

what did you eat yesterday for:														
Breakfast:														
Lunch:														
Dinner:														
Snacks:														
Drinks:														
Is this a typical day for you?														
If not, what does a typical day look like	e?													
Breakfast:														
Lunch:														
Dinner:														
Snacks:														
Drinks:														
How much <b>alcohol</b> do you drink daily?			Weekly?											
Do you <b>smoke</b> ?			How many pack	s p	er d	ay?								
Medical History:			Please rate y	our	en	ergy	y le	vel	s 1-	<b>10</b>				
Do you have or ever had any of the			Upon waking	1	2	3	4	5	6	7	8	9	10	
following:	Yes	No	Mid-morning	1	2	3	4	5	6	7	8	9	10	
Polycystic ovarian disorder			Noon	1	2	3	4	5	6	7	8	9	10	
Ovarian cysts			3 p.m.	1	2	3	4	5	6	7	8	9	10	
Menopause			Before bed	1	2	3	4	5	6	7	8	9	10	
Low testosterone														•
Obstructive sleep apnea			Do you get enough sleep?											
High blood pressure			How many hours per night?											
High cholesterol or Triglycerides  Any difficulties sleeping?														
Diabetes			Staying asleep?											
Insulin resistance			Waking too early?											
Blood clots or clotting disorder														
Gallbladder dysfunction or gallstones			Females only:											
Gallbladder removed			Are you pregnant or breastfeeding?											
		If not, do you plan on getting pregnant?												
			Last menstrual cycle?											
			Are your cycles regular?											
What are your hopes/expectations for the	HCG o	diet?												
Do you think you will be able to follow t	he stric	t dietar	y guidelines while	on	the	die	t? _							
What, if anything, tends to sabotage your														