

HCG MAX™ Diet CLIENT INTAKE FORM

Name _____ Phone _____ e-mail _____

Street Address _____ City _____ State _____ Zip _____

Date of Birth _____ Blood type _____ Age: _____ Referred by _____

Male () Female () Height _____ Weight _____ BMI _____ Hydration _____ Goal Weight _____

HEALTH INFORMATION

 **Circle Current Problems** – **(√) Check Past Problems**

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Diabetes I or II | <input type="checkbox"/> Ulcers / Digestion | <input type="checkbox"/> Bronchial Pneumonia | <input type="checkbox"/> Circulation / Edema |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Breathing Difficulty | <input type="checkbox"/> Acid Reflux |
| <input type="checkbox"/> Prostate | <input type="checkbox"/> Fainting | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Blood Press (High / Low?) |
| <input type="checkbox"/> Parasites | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> PMS | <input type="checkbox"/> Alzheimer's |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Uterus-Cysts or Fibroids | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay fever / Allergies |
| <input type="checkbox"/> Skin problems | <input type="checkbox"/> Throat (sore or mucous) | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Gall bladder | <input type="checkbox"/> Breast (lumps, cysts) | <input type="checkbox"/> Colon / IBS, etc | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Tumors | <input type="checkbox"/> Bladder/Kidney problems | <input type="checkbox"/> Spine/Back/Neck | <input type="checkbox"/> Bloating / Indigestion |
| <input type="checkbox"/> Liver | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Edema (fluid retention) | <input type="checkbox"/> Muscle spasms |
| <input type="checkbox"/> Ovaries / Fibroids | <input type="checkbox"/> Ulcers in Mouth | <input type="checkbox"/> Epstein Barr / Mono | <input type="checkbox"/> Other (explain) _____ |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Herpes | _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Hepatitis C | _____ |

Female Only: Age at onset of menstruation? _____ Age at menopause? _____ Surgically or Naturally occurred?

Any possibility of pregnancy? Yes No # of pregnancies? _____ # of births? _____

1. Briefly outline your weight problems and what you have tried in the past: _____

2. List Prescriptions & over the counter items taken at least once a month (HRT; anti-depressants; aspirin, sinus, Tums, etc)

3. If under a physician's care, for what? _____

4. Occupation _____ 5. Job or career changes in the last 2 years? Yes No

6. Known Allergies? Yes No To which group? Medications Environmental Supplements Chemicals

Animals Perfumes Other _____ 7. Average Stress Level 1 - 10? _____ If stress # is over 6, please explain:

8. # of personal, unresolved issues you find yourself thinking about on occasion _____ (ie: job, friends, loss of loved one, etc)

9. Smoke? Yes No 10. If so, how many per day? _____ 11. # of teeth with metal fillings? _____ (do not leave blank)

12. # of root canals? _____ 13. # of capped or crowned teeth? _____ 14. Use recreational drugs? Yes No

15. Organs removed (include tonsils): _____

16. Do you drink Alcohol? Yes No 17. # of _____ Drinks per Day / Week / Month (please circle one)
18. Total of caffeine drinks a day (coffee-cola)? _____ cups 19. Do you eat chocolate more than 4 X's a week? Yes No
20. Ever lived within 10 miles of a chemical plant/paper plant or lived within 2 – 5 miles of electrical towers? Yes No
21. Exposure to Chemicals, radiation, X-rays, insecticides, cleansers, etc.? Yes No / Any work related exposure? Yes No

If so, please list _____

22. Major injuries in your lifetime? Yes No If yes, please list the type of accident (auto, etc), year, area of body injured?

23. List any lifetime major illnesses (ie: whooping cough, scarlet fever, bronchial pneumonia, mono, meningitis): _____

24. Vigorous/ Cardiovascular exercise sessions per week? _____ What type? _____

25. How many 8 oz glasses of water do you drink every day? _____ 26. What type do you drink?

Distilled Reverse Osmosis Tap Filtered ("Britta-type") Spring Bottled

27. Hrs. a day *near* a computer? _____ 28. Do you use a microwave? Yes No 29. Anti-perspirants or plain deodorant

30. How often do your bowels move? _____ X's a day (or) _____ X's a week Ever too loose? Yes No

31. Circle foods you eat: red meat / pork / turkey / chicken / eggs / fish / crackers / carbonated drinks / diet drinks / green tea / fruit / fried foods / milk / ice cream / cheeses / yogurt / Soy / Processed meats / White or "enriched" bread / organic sprouted breads / beans / vegetables / popcorn / Canola oil / sugar / honey / only organic foods / pasta / cookies / pretzels / peanuts / Equal sweetener

Please list what foods and food - types that you generally eat at these meals: (**Please do not leave blank**)

32. Breakfast: _____ Lunch: _____

Dinner: _____ Snacks _____

Desserts: _____ List any occasional cravings? _____

33. List current Vitamins/Herbs _____

34. I realize I am responsible for my own health and well being Yes No

CLIENT STATEMENT

I understand that I am here to learn about good health practices and I may be offered information and education about the value of life-style changes as a guide to general-good health. I fully understand that those who counsel me are not medical doctors nor dietitians and I am not here for medical-diagnostic purposes, diets or treatment procedures that treat any disease or illness. Services are at all times restricted to the education on the subject of holistic health and are intended for the attainment and maintenance of the best possible state of health.

Services do not involve the diagnosing, treating or prescribing of any programs or remedies for disease or illness and the practitioner / or practitioners have fully explained his/her credentials to me. Recommendations may include natural health practice; nutritional supplements; exercise; educational classes; recommended reading; personal follow-up sessions; and/or referrals to a Medical Doctor or other health practitioners. This in no way obligates me to any recommendations, future visits and no guarantees have been promised to me. I understand that I am free to choose or not to choose to follow any recommendations that may be offered. I am not on this visit or any subsequent visit as an agent for federal, state or local agencies or on a mission of entrapment of investigation.

Signature

Date: