Current Weight:_____
Desired Weight:_____
Desired Completion Date: _____ / _____ / 20 ____

Weight loss can be complex. If you have failed in the past, It could be because you have some of the following…

- ☐ Fatigue
- ☐ Difficulty Getting to Sleep
- ☐ Difficulty Staying asleep
- ☐ High Amounts of Stress
- ☐ Over Heating
- ☐ Cold Hands and Feet
- ☐ Low Sex Drive
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas After a Meal
- ☐ Frequent Urination
- ☐ Sugar Cravings
- ☐ Irritable if Meals are Missed
- ☐ Fatigue After Meals
- ☐ Fibromyalgia
- ☐ Depression
- ☐ Mental Fatigue
- ☐ Menopause
- ☐ Muscle Pain
- ☐ Joint Pain
- ☐ Back Pain
- ☐ Knee Pain
- ☐ Hip Pain
- ☐ Take Pain Medication

If you marked more than 2 on the previous list, you should ask for a Complete Health Evaluation Form.

If there was something you could do about These conditions would want to do so. ☐ YES ☐ NO

I would like to have a Discounted consultation with the doctor about my problem on which day:

Circle One: Mon Tue Wed Thur Fri AM/ PM

Please fill out to qualify for the raffle.

Name_____Occupation_____

Address_____ City_____ Zip_____

Phone where you can be reached_____

Age_____ Email_____

ADVANCED
Weight Loss Program®

Today's Date: _____

Age: ____ Body Fat % _____

Current Weight: _____

Goal Weight: _____

Name: _____ Phone: ( ) _____

Address: _____ City: _____ St _____ Zip _____

Email: _____

1. Why do you personally want to lose weight – ***what's your motive?***

2. How is your **willpower**? – Good Bad Okay *(circle one please)*

3. Are you typically a good **procrastinator**? YES NO

4. Have you had any **lab work / blood tests** lately? (last 3 months) Please list:
   What it was, Where & When…

5. Have you had any **Saliva Tests** done lately? *(in the last 3 months)*
   If "Yes", What were the results and When was it done?

6. What else (**other Diet Programs**) have you tried within the past?

7. Are you ready to have a **Weight Loss Coach** help you get to your goal weight? YES NO

8. Do you have any Neck, Back or Joint pain? YES NO

9. Do you have any other **Health Issue(s)** we need to know about?

   Cancer Diabetes Heart Problems Thyroid other: _____

10. What **Nutritional Products** do you currently take:

Product	Name Brand	Purchase at
Multi-Vitamin		
Calcium		
Fish Oils		
Enzymes		
Other		