HCG Max™ Diet CLIENT INTAKE FORM

Name_____ Phone_____Email_____

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

□ Anemia	□ Arthritis	□ Cancer	□ Insomnia
□ Diabetes I or II	□ Ulcers/ Digestion	□ Bronchial Pneumonia	□ Circulation/ Edema
□ Heart	□ Whooping Cough	□ Breathing difficulty	□ Acid Reflux
□ Prostate	□ Fainting	□ Scarlet Fever	□ Blood press (high/low)
□ Parasites	□ Hypoglycemia	□ PMS	□ Alzheimer's
□ Thyroid	□ Uterus- Cysts on Fibroids	□ Asthma	□ Hey fever/Allergies
□ Skin problems	□ Throat (sore or mucous)	□ Epilepsy	□ Hemorrhoids
□ Gall bladder	□ Breasts (lumps, cysts)	□ Colon/ IBS, etc.	□ Constipation
□ Tumors	□ Bladder/Kidney problems	□ Spine/Back/Neck	□ Bloating/Indigestion
□ Liver	□ Diarrhea	□ Edema (fluid retention)	□ Muscle spasms
□ Ovaries/Fibroids	□ Ulcers in mouth	□ Epstein Barr/Mono	□ Other (explain)_____
□ Chronic Fatigue	□ Fibromyalgia	□ Herpes	_____
□ Depression	□ Jaundice	□ 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 <u>metal</u> fillings? _____ (<u>do not leave blank</u>)

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 4x'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? ☐Y es ☐No

21. Exposure to chemicals, radiation, X-rays, insecticides, cleaners, 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 (Brita-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 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 craving? _____

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 subect of holistic health and are inteded 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 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