PERSONAL REGISTRATION FORM

Date:_________

Patient Name: Last___________________________First____

Address____City_________________ST:_____Zip__________

Phone: Home (____)______-________Work (____)______-________Mobile (___)_______-__________

E-mail: ________________________________Alternate E-mail:_________________________________

Can we call you? Yes____ No____ E-Mail? Yes____ No____ Mail? Yes____ No____

Age:_________Date of Birth: ___________________Sex: M F________ Marital Status: ______________

Height:___________________________Current Weight:____

Occupation: ____

Employer: ____

Address: ____

Street City State Zip

Phone: (______) _____________________________ Extension #: ________________________________

Emergency Contact Info:

Name_____________________Relationship to Patient _____________________Phone_________________

Address: ____

Street City State Zip

Primary Care Physician: ____

Address: ____

Street City State Zip

Phone: (______) _____________________________ Fax: (______) ______________________________

HOW DID YOU FIND US?

Present patient __________________Physician Referral_______________________

On the Internet_____________Friend__________ Phone Book______________________________

Advertisement________Newspaper_________Flyer_______TV__________Radio______________

Were you referred by a friend or coworker? If yes, who____________________________________

PERSONAL HABITS

Do you drink alcohol? Yes___No___

If yes, what kind? ____

How many drinks per week?____

Do you use tobacco? Yes___No___

How many years?____

What kind and how many per day?____

If you previously used tobacco, what year did you quit?__________________________________

Do you currently use recreational or street drugs? Yes___No___

What kind and how many per day?____

WEIGHT HISTORY

Patient Name: Last:___________________________First:_____________________________________

Your current weight:________________What would be your ideal weight?_________________________

Your weight One Year Ago:__________Five Years Ago:_____________Ten Years Ago:______________

Maximum Weight:________________At what age?____

Lowest Weight as an Adult:________________Age:____

Did you consider yourself obese as a teenager? Yes___No___

Have you tried to lose weight in the past? Yes___No___

What Methods? Diets Plans_________________Food Plans_________________ Programs____________

Which Diet Program:________________How long:_________________How much did you lose?______

Do you know why you regained weight? Yes___No___

Type and Frequency of Current Physical Activity:____

Is your Wife/Husband/Partner overweight?____

Is any of your immediate family overweight? If yes please list:__________________________________

Is your weight having an impact on your relationship? Yes___No___

How often do you eat at restaurants and what type of food do you order? __________________________

____

Do you have any food allergies?____

Tell us about your breakfast? Time? Place?____

Tell us about your lunch? Time? Place? ____

Tell us about your dinner? Time? Place?____

What are your worst food habits?____

What foods do you avoid?____

What foods do you crave?____

Do you snack during the day?____

How would you illustrate your body?____

What would you change about your body?____

What does your ideal body look like?____

Comments to help us with your treatment:____

____

____

____

PERSONAL HISTORY

(Confidential)

Patient Name: Last:______________________________First:___________________________________

Do you have any history of the following conditions or symptoms?

Hypertension	Yes___No___	Diabetes	Yes___No___
High Cholesterol	Yes___No___	High Lipid	Yes___No___
Heart Disease	Yes___No___	Glaucoma	Yes___No___
Cyst of Breast or Ovary	Yes___No___	Seizure	Yes___No___
Thyroid Disease	Yes___No___	Alcoholism	Yes___No___
Substance Abuse	Yes___No___	Migraine	Yes___No___
Psychiatric Illness	Yes___No___	Sleep Apnea	Yes___No___

If yes to any of the above, please describe ______________________________________

____

____

Do you have a family history of the following conditions?

Hypertension	Yes___No___	Diabetes	Yes___No___
High Cholesterol	Yes___No___	High Lipid	Yes___No___
Heart Disease	Yes___No___	Glaucoma	Yes___No___
Cyst of Breast or Ovary	Yes___No___	Seizure	Yes___No___
Thyroid Disease	Yes___No___	Alcoholism	Yes___No___

Substance Abuse	Yes___No___	Migraine	Yes___No___
Psychiatric Illness	Yes___No___	Other	Yes___No___

Are you trying for pregnancy? Yes_.__No__._

Have you taken any appetite-suppressing medication before? Yes__._No__._

If Yes: Please list Name and Dosage:____

Psychiatric Illness: Yes_.__No_.__

If yes please describe ____

____

List all operations and dates:____

____

Are you allergic to any medications: Yes___No___, if yes, please list the medications that you are allergic to____

List of current medications that you are taking:

Medication	Dosage	Frequency

Intense Exercise: The patient should understand that highly rigorous exercise should not be performed while on the CMWM diet program because it is too low in calories, carbohydrates and overall nutrient content to remain both healthy and lose weight. Rigorous exercise is considered anything more than one hour of strenuous exercise performed on a daily basis or any kind of training for marathons.

I have answered the questions to the best of my knowledge.

Patient Name________________________

Patient Signature_____________________________ Date______________

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