

hCG Weight Loss Intake Form (please print)

Today's date: _____

Name: _____ Date of Birth: _____ Age: _____

Current Weight: _____ High School Weight: _____ Height: _____

Highest weight/age: _____/_____/_____ Lowest adult weight/age: _____/_____/_____

Medications:

<u>Name</u>	<u>Dosage</u>	<u>Frequency Taken</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Supplements:

<u>Name</u>	<u>Dosage</u>	<u>Frequency Taken</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Types of diets and dates attempted/completed:

- | | |
|----------|-----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |
| 9. _____ | 10. _____ |

What goal are you trying to reach with the hCG diet Weight Loss System? _____

What are you willing to do in order to reach this goal? _____

Are you interested in learning how to change to a healthy lifestyle? Why? _____

