McCaffrey Metabolic Weight Loss – Patient Intake Form

Patient Name: ____ Date: ______________

Address: ______________________________ City: ____________ State: _____ Zip: _______

Email Address: ____ OK to send email: YES/NO

Phone: ______________________________ Cell Phone: ________________________________

Date of Birth: __________ Height: ________ Weight: _________ Desired weight loss: ______

Employer: ____________________________ Occupation: ______________________________

How did you find out about our weight loss program? _________________________________

Are you currently pregnant, breast feeding, having active cancer, or gallbladder issues? YES/NO (If yes, you are not eligible to participating in this program)

Do you experience any of the following conditions even if they are minor and go away on their own? (Please circle any that apply)

High Blood Pressure	Diabetes	Headaches	Hypoglycemia
Cancer	Neck Pain	Upper Back Pain	Thyroid Problems
Heart Disease	Digestive Problems	Arthritis	Chronic Fatigue
Fibromyalgia	Numbness	Stress/Irritability	Sinus/Allergy
Hip/Knee Pain	Osteoporosis	Chronic Inflammation	Car Accident(s)
Dizziness	Ringing in Ears	Indigestion	Other

** Are you currently on any medications/vitamins and for what health condition?

During this weight loss journey, you will be undergoing an outstanding transformation. To further assist you we would appreciate you listing any and all current health ailments that affect your quality of life.

1.____

2. ____

3. ____

4. ____

5. ____

6. ____

7. ____

8. ____