

AGELESS INTEGRATIVE MEDICAL SPA
WEIGHT MANAGEMENT PROGRAM
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NAME: _____	DOB: _____	
HEIGHT: _____	WEIGHT: _____	WEIGHT GOAL: _____

ALLERGIES: _____
CURRENT MEDS: _____

SMOKING HISTORY: NEVER/FORMER/CURRENT

ALCOHOL: NEVER/RARE/OCCASIONAL/DAILY

HISTORY

ANY ISSUES WITH –
FATIGUE, LOW ENERGY, WEIGHT GAIN _____
EYES: _____
EAR, NOSE, OR THROAT: _____
HEART(INCLUDING HIGH BLOOD PRESSURE AND CHOLESTEROL): _____

LUNGS: _____
STOMACH _____
GENITAL/URINARY: _____
MUSCLE/SKELETAL: _____
SKIN/HAIR/NAILS: _____
NEURO(MIGRAINES, SEIZURES): _____
PSYCHIATRIC: _____

SURGERIES OR
ILLNESS: _____

EXERCISE HABITS(IF ANY): _____

DIETARY HABITS(IE. VEGETARIAN): _____

OCCUPATION: _____