

**Confidential Application for joining the  
UltraLite Health & Weight Management System**

**Name:** \_\_\_\_\_ **Today's Date** \_\_\_\_\_

**Weight:**

Your weight today: \_\_\_\_\_ Your height: \_\_\_\_\_ Your target weight: \_\_\_\_\_

**Diet:**

What other weight loss programs have you tried? \_\_\_\_\_

Are you a vegetarian or vegan? \_\_\_\_\_

Do you use coffee? \_\_\_\_\_ Alcohol? \_\_\_\_\_ Tobacco? \_\_\_\_\_

**Exercise:**

Do you exercise? \_\_\_\_\_ What type of exercise do you do? \_\_\_\_\_

How often do you exercise? \_\_\_\_\_ For how long do you exercise? \_\_\_\_\_

Please circle if you have even been diagnosed with any of the following conditions:

- Cancer
- High blood pressure
- High cholesterol
- Heart disease
- Stroke
- Diabetes
- Metabolic Syndrome/Insulin Resistance
- Hypoglycemia
- Thyroid Disease
- Epilepsy/Seizures

What other medical conditions have you experienced in the past 5 years?

\_\_\_\_\_

Last Blood Pressure reading: \_\_\_\_\_ Date of this reading: \_\_\_\_\_

Are you pregnant or trying to get pregnant? \_\_\_\_\_

Are you currently breast feeding? \_\_\_\_\_

Are you planning to have any surgery, or have you recently undergone surgery in the past 6 months? If so, describe: \_\_\_\_\_

**The following are some reactions that are occasionally experienced by some people when losing weight.**

Please print yes or no [*or the letter "Y" or "N"*] where and if application with regards to your previous experience on weight loss programs or diets.

- Feeling Nauseated: \_\_\_\_
- Headaches: \_\_\_\_
- Change in menstrual periods: \_\_\_\_
- Sleeping problems: \_\_\_\_
- Weakness: \_\_\_\_
- Plateaus: \_\_\_\_
- Hair thinning: \_\_\_\_
- Hunger Pangs: \_\_\_\_
- Lethargy: \_\_\_\_
- Specific or general cravings: \_\_\_\_
- Feeling light-headed: \_\_\_\_
- Leg cramps: \_\_\_\_
- Any other reactions you might have had: \_\_\_\_\_

Once you reach your goal, would you be willing to share your experience with others?

\_\_\_\_\_

I believe that the above information is true and correct. I understand that I undertake the ULTRA LITE program at a cost of \$145 (patient discounted price) the first week, \$75 (patient discounted price) every following week, which is non-refundable and non-transferable. I also understand that I undertake the ULTRA LITE program entirely at my own risk and that my ULTRA LITE practitioner will endeavor to take all due care.

Your signature: \_\_\_\_\_ Date: \_\_\_\_\_