



**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 ever 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: \_\_\_\_\_

**Current Medications:**

| <u>Medication</u> | <u>Dose/Frequency</u> | <u>For how long?</u> | <u>For what reason?</u> |
|-------------------|-----------------------|----------------------|-------------------------|
|                   |                       |                      |                         |
|                   |                       |                      |                         |
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|                   |                       |                      |                         |

**Current Supplements: (include all vitamins, herbs, homeopathy, or other supplements)**

| <u>Supplement</u> | <u>Dose/Frequency</u> | <u>For how long?</u> | <u>For what reason?</u> |
|-------------------|-----------------------|----------------------|-------------------------|
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**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?

\_\_\_\_\_

**INFORMED CONSENT:**

Drs. Eric and Kristina Lewis are Naturopathic Doctors. They are co-owners of Lewis Family Natural Health, Inc.

Both doctors graduated from the Southwest College of Naturopathic Medicine in Tempe, Arizona, a 4-year post-graduate medical school accredited by the US Department of Education. They carry licenses to practice medicine in the state of Vermont. In the state of Vermont, Naturopathic Medicine is regulated by the Vermont Secretary of State's Office of Professional Regulation of Naturopathic Physicians under Vermont Statutes, Title 21, Chapter 81, Section 4121 through 4132.

Dr. Eric Lewis and Dr. Kristina Lewis are licensable in all states licensing Naturopathic Physicians. At this time, there is no such license available in the state of North Carolina. They are therefore not licensed to diagnose or treat disease in North Carolina. As a result, they do not intend to nor imply to diagnose and treat disease. The advice provided by the doctors is educational and intended to complement, not replace, any treatment prescribed by a licensed physician.

I understand the above statement. I further understand that Lewis Family Natural Health, Inc., and its associates, Dr. Eric Lewis and Dr. Kristina Lewis, are not medical doctors and are not attempting to conduct the activities of medical doctors.

I understand that I undertake the ULTRA LITE program at a cost of \$155 the first week, \$85 every following week, which is non-refundable. I also understand that my ULTRA LITE program is not transferable. I also understand that I undertake the ULTRA LITE program entirely at my own risk and that my ULTRA LITE practitioners will endeavor to take all due care.

Patient or Responsible Party's Signature: \_\_\_\_\_

Printed name: \_\_\_\_\_ Date: \_\_\_\_\_