MOXIFIT™
Health & Wellness Profile

General Information

First Name: _____ Last Name: _____ Date: _____

Address: _____ Apt/Unit #: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Date of Birth: _____ Age: _____ Height: _____

Profession: _____ How did you hear about us?_____

Personal Information

Marital Status: Married Single Divorced Widowed

Current Weight: _____ Goal Weight: _____

Number of Children: _____ How many currently live with you & their ages: _____

Do you smoke? Y / N If yes, how much _____

Do you Exercise? Y / N If yes, what kind? _____

How often? _____ Daily _____ Weekly _____ Other

Have you dieted before? Y / N If yes, please specify: _____

Rate your sleep: 0 (poor), 10 (excellent, 8 hours) _____

Do you have sleep apnea? Y / N Do you use any sleep aids or medication? Y / N _____

Which do you prefer? _____ Sweet Foods _____ Salty Foods _____ Fatty Foods

How many glasses of water do you drink per day? _____ glasses

How many 8 oz. cups of coffee do you drink per day?

_____ cups _____black _____cream _____ sweetener

Do you drink tea? Y / N _____ black _____ green _____ sweet _____ unsweetened

Do you drink soda pop? Y / N _____ Diet _____ Regular _____ None

Do you drink alcohol? Y / N If yes, what type and how often?_____

Are you able to stop drinking alcohol to lose the weight? Y / N

Are you a stress eater? Y / N _____ Emotional _____ Impulsive

Eating Patterns

Breakfast

Do you eat breakfast every morning? Yes / Sometimes / Never Approximate time: _____

Examples of breakfast foods: _____

Do you snack before lunch? Yes / Sometimes / Never Approximate time: _____

Examples of snack foods: _____

Lunch

Do you eat lunch every day? Yes / Sometimes / Never Approximate time: _____

Examples of lunch foods: _____

Do you snack before dinner? Yes / Sometimes / Never Approximate time: _____

Examples of snack foods: _____

Dinner

Do you eat dinner every day? Yes / Sometimes / Never Approximate time: _____

Examples of dinner foods: _____

Do you snack at night? Yes / Sometimes / Never Approximate time: _____

Examples of snack foods: _____

General

On a scale of 1 - 10

1) Indicate how important losing weight is for you? _____ improving overall health?_____

Rate your stress level on a scale of 1 - 10 for the following categories:

_____ Work/Professional _____ Family/Relationships _____ Money _____ Health _____ Self-Related

Please explain what is your reason for meeting with us:

_____

_____

Please answer Yes (Y) or No (N) to the following:

_____ I am prepared to take back control over how, and what I am eating and I know it is my responsibility.

_____ I am prepared and open to learning how to develop new practices & habits.

_____ I am aware that my current habits created the body that I live in, and I am ready to change.

_____ I am prepared to speak up for myself regarding my nutritional and health needs.

_____ I am prepared to commit to changing even when it is not easy.

Allergies

Do you have any food allergies or sensitivities? Y / N

If yes, please specify: _____

_____

Medical Information

Who is your primary care physician (family doctor)?

Dr. _____ Speciality: _____ Patient since: _____

Dr. _____ Speciality: _____ Patient since: _____

Diabietes

Do you have diabetes? Y / N If NO, please skip this section

If yes, which type:

_____ Type I: Insulin-Dependent (insulin injections only) **TYPE 1 - MUST DO FLEX PROGRAM**

_____ Type II: Non-dependent (diabetic pills)

_____ Other: Insulin-dependent (diabetic pills & insulin)

Is your blood sugar level monitored? Y / N If yes, how often? _____

By whom? _____ Self _____ Physician _____ Other Please specify _____

Note: If you are currently on a Sodium-Glucose Co-Transporter Inhibitor (SGLT-2)

YOU MUST DO FLEX PROGRAM.

Endocrine Function

Do you have thyroid problems? Y / N If NO, please skip this section

_____ Hypo _____ Hyper _____ Hashimoto's

If yes, please specify: _____

Do you have parathyroid problems? Y / N

If yes, please specify: _____

Do you have adrenal gland problems? Y / N

If yes, please specify: _____

Have you been told you have Metabolic Syndrome? Y / N

Cancer

Do you have cancer? Y / N If yes, what type and where: _____

Have you ever had cancer? Y / N If yes, what type and where: _____

Is your cancer in remission? Y / N If yes, how long: _____

Cardiovascular Function

Have you had any of the following conditions?

_____ Arrhythmia

_____ Blood Clot

_____ Coronary Artery Disease

_____ Heart Attack When? _____

_____ Heart Valve Problem

_____ Heart Valve Replacement
(Porcine/mechanical)

_____ Pacemaker or Defibrillator

_____ Hyperlipidemia
(high cholesterol/triglycerides)

_____ Hyperkalemia (high potassium)

_____ Hypokalemia (low potassium)

_____ Hypertension (high blood pressure)

_____ Pulmonary Embolism

_____ Stroke or Transient Ischemic Attack

_____ Current Congestive Heart Failure

_____ History of Congestive Heart Failure

When? _____

Have you had any type of heart surgery? Y / N

If yes, which type: _____

Do you check your blood pressure regularly? Y / N How often? _____

Are you currently taking any Blood Pressure medications? Y / N

Has your physician restricted your sodium intake? Y / N

Liver Function

Have you ever had any liver conditions? Y / N Date: _____

If yes, please list: _____

Have you ever had a gallstone incident? Y / N

Do you still have your gallbladder? Y / N

Kidney Function

Have you had any of the following conditions?

_____ Kidney Disease (NPA)

_____ Kidney Stones

If yes, when was your last episode?

_____

How was it resolved? _____

_____ Kidney Transplant

If yes, when? _____

Do you presently have gout? Y / N

If yes, since when? _____

If yes, what medication has been prescribed?

_____

If no, have you ever had gout? Y / N

If yes, when? _____

If yes to any of these events, please give dates. For multiple events please specify:

_____

_____

Colon Function

Do you have any of the following conditions?

_____ Constipation *(occasional or chronic)*

_____ Diverticulitis

_____ Ulcerative Colitis

_____ Diarrhea *(occasional or chronic)*

_____ Crohn's Disease

_____ Irritable Bowl Syndrome

Digestive Function

Do you have any of the following conditions?

_____ Acid Reflux

_____ Gastric Ulcer

_____ Gluten Intolerance

_____ Celiac Disease

_____ Heartburn

_____ Bariatric Surgery

If yes to bariatric surgery, what type & when? _____

Ovarian/Breast Function

Do you have any of the following conditions?

_____ Amenorrhea (no menstration)
_____ Irregular Periods
_____ Fibrocystic Breasts
_____ Heavy Periods
_____ Painful Periods
_____ Hysterectomy
_____ Menopause
_____ Uterine Fibroma

Date of last menstrual cycle: _____ Are you taking oral contraceptives? Y / N

Are you pregnant? Y / N Are you breast feeding? Y / N

Neurological/Emotional Function

Do you have any of the following conditions?

_____ Alzheimer's Disease
_____ Depression
_____ Anorexia (history of)
_____ Epilepsy
_____ Panic Attacks
_____ Bipolar Disorder
_____ Bulimia (history of)
_____ Schizophrenia
_____ Anxiety
_____ Parkinson's Disease

Other: _____

Inflammatory Conditions

Do you have any of the following conditions?

_____ Chronic Fatigue Syndrome
_____ Multiple Sclerosis
_____ Rheumatoid Arthritis
_____ Lupus
_____ Migraines
_____ Osteoarthritis
_____ Psoriasis
_____ Fibromyalgia
_____ Sarcoidosis

Other autoimmune or inflammatory conditions: _____

Medication & Supplements

Please list all prescriptions, medications, & supplements you are currently taking
(Refer to the examples in the first line)

Name of medication	Milligrams* per capsule	Number of capsules per day	Number of doses per day	Prescribing doctor	Reason for taking this medication
Levoxyl	15mg	1	1 x a day	Dr. John Doe	Thyroid

*or grams, mEg or dosage unit your doctor prescribes you

Medical Disclaimer & Waiver

I, _____ understand, acknowledge, and affirm the following: _____ (clinic name), is not a medical facility, and its consultants and staff cannot, have not, and will not give medical advice, diagnosis or treatment, whatsoever.

Nothing discussed, nor any information, or products provided to me by _____ (clinic) or the Moxifit Program in any way constitutes medical advice or a diagnosis.

Any reports, information, documentation, or advice generated or provided to me by _____ (clinic) is for my education or knowledge and does not constitute or substitute for a physician or healthcare professional consultation, evaluation, or treatment.

I, _____ (initial) acknowledge that it is my responsibility/choice to consult with my physician prior to beginning the Moxifit Program or any weight loss program. I declare that I have been advised by _____ (clinic) to seek the advice of my physician regarding any health questions I may have.

I, _____ (initial) recognize that Moxifit is a weight-loss program and any information provided by _____ (clinic) is for my knowledge only and does not substitute for professional medical advice.

I, _____ (initial) declare that I have not, and will not, rely on any information provided to me by _____ (clinic) or its consultants, staff or representative as an alternative to medical advice from my doctor or professional healthcare provider.

By signing this disclaimer and waiver I, _____ (printed name) do hereby release, remiss, acquit and forever discharge _____ (clinic) respective past, present and former parents, subsidiaries, employees, agents, representatives, consultants, attorneys, fiduciaries, servants, officers, directors, general partners, limited partners, members, participants, predecessors, affiliates, corporate divisions, successors, and assigns of, from and against any and all causes of action, claims, demands, damages, costs, losses, injuries, and suits of any kind or nature, known or unknown, existing, claimed to exist or which can be hereinafter ever arise out of result from or in connection with any act, omission, failure to act, breech of conduct suffered to be done or omitted to be done arising directly or indirectly from my participation in the Moxifit program.

CLIENT SIGNATURE: _____ DATE: _____

CLINIC SIGNATURE: _____-_____ DATE: _____