PERSONAL INFORMATION FORM

Today's Date:		Consultant/Coach Name:	
CLIENT INFORMATION			
Last name:	First:	Middle:	Marital status:
Address:	City		Zip
Email:	Home phone no.:		Cell phone no.:
Occupation:	Birthdate:	Age:	

How did you hear about us?

MEDICAL HISTORY

Are you currently under the care of a physician for any health conditions? ☐ Yes ☐ No Please explain:

Are you currently taking medications? ☐ Yes ☐ No Please list medications and explain what you are taking them for:

If you have any of the following health conditions – PLEASE STOP – and speak with a Lifestyle Coach.

☐ Pregnancy ☐ HIV/AIDS ☐ Hepatitis C/D ☐ Active Cancer ☐ Mental Disorders

☐ Pacemaker ☐ Severe kidney or liver conditions ☐ Blood Clots (active/inactive)

Have you had any surgeries? ☐ Yes ☐ No If yes, please list what procedure and when:

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list what they are and what type of reaction:

Please list any other disease or health conditions you have been diagnosed with:

Do you have at least one (1) full bowel movement daily? ☐ Yes ☐ No

Do you experience any heartburn, nausea, excessive belching, lower bowel gas, stomach aches or pain? ☐ Yes ☐ No

Have you ever suffered from yeast infections and/or overgrowth of candida? ☐ Yes ☐ No

Do you currently take any nutritional supplements? ☐ Yes ☐ No Please list nutritional supplements and explain what you are taking them for:

Women: Date of last period: Do you take hormone replacements?

Men: Do you take hormone replacements?

Have you used any other body sculpting services in the past? (Liposuction, cool sculpting, gastric bypass, lap band, plastic surgery)?
☐ Yes ☐ No
If yes, list type and what your results were:

Are there any other health conditions or concerns you have?

LIFESTYLE

How much water do you drink daily?

Exercise: Type and how often

Do you smoke? ☐ Yes ☐ No How often? Do you drink alcohol? ☐ Yes ☐ No How often?

What are your body solution goals?

Lose weight: ☐ Yes ☐ No How much?_____ Lose inches? ☐ Yes ☐ No Tone/tighten skin ☐ Yes ☐ No
Minimize cellulite ☐ Yes ☐ No
Other:

What area of the body are you looking to improve? ☐ Lower Abdomen ☐ Upper Abdomen ☐ Lower Back
☐ Upper back ☐ Arms ☐ Inner Thighs ☐ Outer thighs ☐ Chin
Other:

How committed are you to achieving your results? (1-not likely, 10 totally committed)

What is your motivation for weight loss or body sculpting?

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Evolve Now or insurance company to release any information required to process my claims.

Patient/Guardian Signature: Date: