

Current Weight:_____ Desired Weight:_____

Desired Completion Date:_____

Weight loss can be complex. If you have failed in the past, it could be because you have some of the following

- | | | |
|--|--|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Gas after a meal | <input type="checkbox"/> Muscle pain |
| <input type="checkbox"/> Difficulty getting to sleep | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Difficulty staying asleep | <input type="checkbox"/> Sugar Cravings | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> High amounts of stress | <input type="checkbox"/> Irritable if meals are missed | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Over heating | <input type="checkbox"/> Fatigue after meals | <input type="checkbox"/> Hip pain |
| <input type="checkbox"/> Cold hands and feet | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Take pain medication |
| <input type="checkbox"/> Low sex drive | <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Mental fatigue | |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Menopause | |
| <input type="checkbox"/> Constipation | | |

If you filled out more than 2 of the following, you should ask for a complete health evaluation form.

If there was something you could do about these conditions would want to do so. YES NO

I would like to have a Discounted consultation with the doctor about my problem on which day:

Circle One: Mon Tue Wed Th Fri AM/ PM

Please fill out to qualify for the raffle.

Name_____Occupation_____

Address_____City_____Zip_____

Phone where you can be reached_____

Age_____Email_____