

Transformations28 Program

- Two payment options for T28 - \$499 up front or \$130 weekly. Please be prepared to let us know which payment option you would like.

First & Last Name: _____

Home Address: _____ City, State & Zip: _____

Date of Birth: _____ Age: _____

Most Accessed Telephone Number: _____

E-mail: _____ Profession: _____ Employer: _____

Primary Care Physician: _____ Height: _____ Current Weight: _____ lbs.

Min. Adult Weight: _____ lbs. at age _____ Maximum Weight: _____ lbs. at age _____

Do you exercise? Yes No

If yes, what kind? _____

Which Transformations location do you plan on attending? Savoy Monticello

How did you hear about Transformations? (Please check all that apply)

___ Referral from my physician _____ ___ Brochure ___ Radio ad

___ TV ___ Web site/Google ___ Referred from another dieter _____

___ Other _____

When do you want to get started? _____

What is your goal weight or desired goal(s) related to your health, wellness, looks, size etc?

Allergies

Do you have any allergies to milk, soy or sucralose? Yes No

Which one of these? _____

Medical Conditions

- Do you have diabetes? Yes No
- Do you have any cardiac problems? Yes No
- Do you have a history of rhythm problems? Yes No
- Do you have high blood pressure? Yes No
- Do you have any kidney issues? Yes No
- Do you have a history of kidney stones? Yes No
- Do you have thyroid problems? Yes No
- Do you have cancer? Yes No
- Do you have liver problems? Yes No
- Have you ever had Gout? Yes No
- Are you pregnant? Yes No
- Are you breastfeeding? Yes No
- Do you have other health problems?** Yes No

If so, please specify: (Cholesterol Issues, recent surgeries, etc..)

Medications - please fill out the following chart if you are on less than 2 medications.

If you are on more than two PLEASE ATTACH YOUR MEDICATION LIST, and this may mean you do not qualify for the quick plan.

Name of Medication	How many mg is each table?*	How many tablets do you take each day?	How often do you take a dose?	Prescribed by whom?	Why do you take this medication?
Vitamin X	500mg	1	1x a day	Dr. John Doe	Omega 3

*or mEq or dosage your doctor prescribes.

I agree to use the Ideal Protein foods, vitamins and minerals purchased from the Transformations Clinic while on the Ideal Protein Weight-Loss Method. Failure to comply with this purchase agreement could lead to undesirable health side effects and dismissal from the Transformations T28 program. Additionally, if I pay weekly and choose to stop the program before completing it, I will be responsible for the remaining cost of the supplements and joining fee.

(Client's initials) _____

The signatory client hereby recognizes the veracity of the information provided herein and that he/she has made an informed decision to go on the Ideal Protein Weight Loss Method.

Signature: _____ Date: _____

Client Please list any relevant notes for our provider and or health coach:

-----For Office Use Only-----

Date: _____

Total	___	Sodium	___
Trigly.	___	Potassium	___
HDL	___	BUN	___
LDL	___	Creatinine	___
Glucose	___		
A1C	___		

Please list at least 5 reasons why you want to do this program.

1. _____

2. _____

3. _____

4. _____

5. _____

Many of us have several reasons why losing weight is important. Keep these 5 things handy and review them periodically or when you may feel you need a reminder. Remembering why we are doing something can be very helpful.

"There is no such thing as I can't. If there's a will, there's a way!"