

## 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..)

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**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:

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-----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!"