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:_____

Height:_____ 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!"