TheFatLossExpert.com

Date _____

Dr.Terry M. Gibson D.C.

Name_____Occupation_____

Address_____City_____Zip_____

Phone_____Age_____Email_____

Date of birth_____How did you hear about us? _____

Hobbies/Activities_____Is your weight interferring with any of these? -- Y -- N

Who is your Primary Care Physician?_____

Current Weight:_____Desired Weight:_____Height:_____

Marital Status: ☐Married ☐Single ☐Partner ☐Separated ☐Divorced ☐Widow(er)

Weight loss can be complex. If you have failed in the past, our Metabolism Reset Solution can be your answer.

Please check any of the following that apply to your health.

- ☐ Fatigue
- ☐ Difficulty getting to sleep
- ☐ Difficulty staying asleep
- ☐ High amounts of stress
- ☐ Over heating
- ☐ Cold hands and feet
- ☐ Low sex drive
- ☐ Thyroid Problem
- ☐ Diabetes
- ☐ Acid Reflux
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas after a meal
- ☐ Frequent urination
- ☐ Sugar Cravings
- ☐ Irritable if meals are missed
- ☐ Fatigue after meals
- ☐ Fibromyalgia
- ☐ Gallbladder Removed? ☐ Yes ☐ No
- ☐ Depression
- ☐ Mental fatigue
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Back pain
- ☐ Neck pain
- ☐ Knee pain
- ☐ Hip pain
- ☐ Heart problems
- ☐ Total number of meds taking _____

What programs have you tried in the past? _____

Your results? _____

Any other health problems? _____

If I could give you just ONE RESULT OR OUTCOME by us working together, what would that be?

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