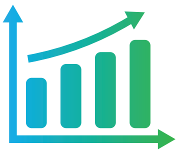

MOXIFIT™
Health & Wellness Yearly Update

General Information

First Name: ____________________ Last Name: ______________________________ Date: ____________

Address: ____ Apt/Unit #: ____________

City: ____ State: _____________________ Zip: ______________

Phone: ________________________ Email: ____

Date of Birth: ______________________ Age: __________ Height: ______________

Profession: ________________________ How did you hear about us?____________________________

Personal Information

Marital Status: Married Single Divorced Widowed

Current Weight: __________ Goal Weight: __________

Number of Children: _____ How many currently live with you & their ages: ___________________

Do you smoke? Y N If yes, how much ______________

Do you Exercise? Y N If yes, what kind?_____________________________ _______________

How often? Daily Weekly Other

Have you dieted before? Y N If yes, please specify: ___________________

Rate your sleep: 0 (poor), 10 (excellent, 8 hours) __________

Do you have sleep apnea? Y N Do you use any sleep aids or medication? Y N

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On a scale of 1 - 10,

1) Indicate how important losing weight is for you? _______

2) Indicate how important it is to you to learn how to build a foundation for a new lifestyle? _____

Rate your stress level on a scale of 1 - 10 for the following categories:

_____ Work/Professional _____ Family/Relationships _____ Money _____ Health _____ Self-Related

List 3 reasons why this program and losing weight is important to do NOW:

1)____

2)____

3)____

Please answer Yes (Y) or No (N) to the following:

_______ I understand that I have control over my eating and it is my responsibility.

_______ I am willing to put forth the effort to develop new habits/practices.

_______ I am aware that my current habits created the body that I live in.

_______ I can speak up for myself regarding my nutritional and health needs.

_______ I am committed to changing even when it is not easy.

Medical Information

Who is your primary care physician (family doctor)?

Dr. ______________________________ Speciality: ____________________ Patient since: __________

Dr. ______________________________ Speciality: ____________________ Patient since: __________

Allergies

Do you have any food allergies or sensitivities? _____ Y _____ N

If yes, please specify: ____

____

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Medication & Supplements

None ______ (initials)

Please list all prescriptions, medications, & supplements you are currently taking
(Refer to the examples in the first line)

Name of medication	Milligrams* per capsule	Number of capsules per day	Number of doses per day	Prescribing doctor	Reason for taking this medication
Levoxyl	15mcg	1	1 x a day	Dr. John Doe	Thyroid

*or grams, mEg or dosage unit your doctor prescribes you

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Medical Disclaimer & Waiver

I, ________________________________ understand, acknowledge, and affirm the following: ___________________________________ (clinic name), is not a medical facility, and its consultants and staff cannot, have not, and will not give medical advice, diagnosis or treatment, whatsoever.

Nothing discussed, nor any information, or products provided to me by ___________________ (clinic) or the Moxifit Program in any way constitutes medical advice or a diagnosis.

Any reports, information, documentation, or advice generated or provided to me by _________________________ (clinic) is for my education or knowledge and does not constitute or substitute for a physician or healthcare professional consultation, evaluation, or treatment.

I, _____ (initial) acknowledge that it is my responsibility/choice to consult with my physician prior to beginning the Moxifit Program or any weight loss program. I declare that I have been advised by _____________________ (clinic) to seek the advice of my physician regarding any health questions I may have.

I, _____ (initial) recognize that Moxifit is a weight-loss program and any information provided by ____________________ (clinic) is for my knowledge only and does not substitute for professional medical advice.

I, _____ (initial) declare that I have not, and will not, rely on any information provided to me by ______________________ (clinic) or its consultants, staff or representative as an alternative to medical advice from my doctor or professional healthcare provider.

By signing this disclaimer and waiver I, _____________________________ (printed name) do hereby release, remiss, acquit and forever discharge __________________________ (clinic) respective past, present and former parents, subsidiaries, employees, agents, representatives, consultants, attorneys, fiduciaries, servants, officers, directors, general partners, limited partners, members, participants, predecessors, affiliates, corporate divisions, successors, and assigns of, from and against any and all causes of action, claims, demands, damages, costs, losses, injuries, and suits of any kind or nature, known or unknown, existing, claimed to exist or which can be hereinafter ever arise out of result from or in connection with any act, omission, failure to act, breech of conduct suffered to be done or omitted to be done arising directly or indirectly from my participation in the Moxifit program.

CLIENT SIGNATURE: ________________________________ DATE: ____________________

CLINIC SIGNATURE: __________-____________________ DATE: ____________________

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