Platinum Weight Loss Center
Wellness & Aesthetics

Intake Form

Name: (First) (Last) (MI)

Age: Sex: M or F

Date of Birth: (Month) (Day) (Year)

Home Address:
(Street)
(City)
(State)
(Zip)

Contact Information:

Phone Number: (Cell) (Home)

E-mail:

Physician (Primary Care/Internist):

Emergency Contact:
Name: Relationship: Phone:

Occupation/Employer:

How did you hear about us? (Please circle all that apply)
Direct Mail Web Site Friend
Brochure TV

What are your goals for weight loss?

Hstory of eating disorders?

Prior diets: