



Date.....

Name: Age: Sex:

Address:..... Hight:.....

Birth date..... Occupation:..... City:

E-mail address Phone:.....

Facebook ID

*How you came to know about FitBack Reset?

Do you use cigarettes/tobacco?: ☐ Yes ☐ No

Check the conditions that apply member of your immediate relatives:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Cardiac disease	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Thyroid
<input type="checkbox"/> PCOS/PCOD	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	<input type="checkbox"/>

Personal Issues

<input type="checkbox"/> Asthma	<input type="checkbox"/> Cardiac disease	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Thyroid
<input type="checkbox"/> PCOS/PCOD	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	<input type="checkbox"/>

Are you currently taking any medication?

Are you currently taking Other Weight loss medicine/Supplement/Services/Injection

Do you have any medication allergies

Physio's Note