Please scan and email or hand deliver your completed paperwork to Mark@TheDynamicBody.com
Thank you!

All Provided Information is kept Strictly Confidential.

Name:				Date:
Address:			Country:	
City:		State:		Zip/Postal Code:
Home Phone:		Work Phone:		Fax:
E-mail:			Cell Phone:	
Please mark your preference for occasional follow up communication from our office: _____Email _____Phone				
Age:	Birth date:	Sex: M F	Status: M S W D	No. Children:
Occupation:		Employer:		Years Employed:
Spouse's Name:		Occupation:		Employer:
Person responsible for this account:				Doctor/Physician:
What are Your overall fitness and wellness goals?				
Do you have any concerns or complaints?				
Are you currently engaging in exercise and/or dieting? What methods are you using?				
Any other details you think might be useful for me to know?				

Weight _____ **Height** _____ **Blood Pressure** (if known) _____ **% Body Fat** (if known) _____

1. Please list any medications, nutritional supplements or vitamins you are taking? _____
_____
_____

2. In the past, have you used birth control pills? Y/N
If yes, for how long and when? _____

3. If you have fillings, please list material(s) used: _____

4. Do you presently, or have you ever had any of these conditions? (circle)

Anemia	Frequent Headaches	Skin condition
Arthritis	Heartburn	Thyroid condition
Asthma	High blood pressure	Unexplained weight change
Chest pains	High cholesterol	
Chronic cold/flu symptoms	Hypoglycemia	
Chronic fatigue	Kidney problems	
Depression	Liver problems	
Diabetes	Osteoporosis	

5. How much sleep do you get each night on average? _____

6. Do you have any food allergies, sensitivities or restrictions? _____
_____
_____

7. Do you smoke, drink alcohol or use recreational drugs? _____

a. How much, how often? _____

b. How often do you drink caffeinated beverages? _____

8. Please list foods you tend to overeat or crave (Sweets, breads, fatty foods, meats, milk, etc.): _____

_____

9. Are there foods that you eat on a daily basis, almost daily basis? _____

_____

a. Do you "miss" these foods if you do not eat them? _____

10. Write briefly about your weight gain/loss history: _____

_____

a. What do you feel triggered your weight fluctuation? (circle) heredity stress eating habits boredom

b. Was your weight gain/loss: (circle) sudden gradual problem since childhood

11. Please list close relatives that have diabetes, heart disease or obesity: _____

_____

12. What methods have you tried to lose/gain weight? _____

_____

_____

13. How is your energy level? _____

a. Are there times in the day that you feel best? _____worst? _____

14. Are you happy in your life right now? _____

15. What are your main sources of stress?

_____

_____

16. How do you deal with your stress?

_____

_____

17. Please answer the following questions Yes or No:

a. If I'm feeling down, a snack makes me feel better. Yes_____ No_____

b. I sometimes have a hard time going to sleep without a bedtime snack. Yes_____ No _____

c. I get tired and/or hungry in the mid-afternoon. Yes_____ No_____

d. I get a sleepy, almost "drugged" feeling after eating a meal containing bread, pasta or dessert. Yes_____ No _____

e. Now and then I think I am a secret eater. Yes _____ No_____

f. At a restaurant, I almost always eat too much bread before the meal is served. Yes_____ No_____

g. I have difficulty concentrating, or frequent fuzzy or spacey thinking patterns. Yes_____ No_____

h. I experience cravings for sugar, breads, pasta and baked goods. Yes _____ No_____

i. I feel shaky if I don't eat on time or if I don't snack. Yes_____ No_____

j. I often find myself irritable or angry. Yes_____ No_____

18. Surgeries: _____

19. Hospitalizations: _____

20. Where were you born and where have you lived? _____
_____
_____

21. Check off any of the following that apply to you:

_____Do you feel nauseous?

_____Do you have abdominal/intestinal pain?

_____Do you have bloating?

_____Do you get bloated after meals?

_____Do you get heartburn?

_____Do you have diarrhea?

_____Do you have constipation?

_____Do you travel outside of the U.S.?

_____Do you have gas?

_____Are your stools compact/hard to pass?

_____Do you belch following meals?

_____Do you have gurgles in your stomach?

_____Do your bowel movements alternate between constipation and diarrhea?

22. In your estimation, how physically fit are you right now?

Unfit_____ Below average_____ Average _____ Above average_____ Very fit_____

23. How often do you exercise? _____

a. What kind of exercise do you do? _____

_____

24. If you do not currently exercise, what types of exercise have you enjoyed doing in the past? _____

_____

25. What are your fitness goals?
_____

26. What is your typical Breakfast: _____
What is your typical Lunch: _____?
What is your typical Dinner: _____?

27. Have you ever had Food Poisoning? _____

POLICIES AND PROCEDURES
(please read and sign)

Fee Schedule:

Functional Investigative Testing (F.I.T) and Health Coaching: $95 per hr. or $50 per ½ hr.

Physical Assessment, Program Design, Exercise Instruction: each $95 per hr.

Pre-paid Package of 10 - Assessment and 9 Personal Training Sessions - $900

Semi-Private (maximum of 3 clients) Sessions - $50 per person

- Methods of payment are: Cash, Check, Visa or MasterCard.
  (add $5 per $100 for Square, Inc. Credit Card processing)

- All consultations and sessions are timed from the time the appointment begins; as your session is scheduled as your time, any lost time due to being late cannot be guaranteed to extend beyond the originally scheduled appointment.

Consultations

- Follow-up F.I.T. consults may be scheduled in 30 or 60-minute blocks of time.
- It's best to book your sessions two weeks in advance to make sure you have the best time for you.
- If this is a phone session, Mark will call you at the time of your scheduled consultation. He works with a precise schedule, so please keep your phone line clear.

Lab Tests

- The results of your lab test(s) will be sent to Mark Herbert 2 - 4 weeks after mailing your specimens to the lab. Once your results have arrived, a follow-up consultation will be scheduled as soon as possible.

Cancellations

- If you are unable to keep your scheduled appointment, please notify Mark a **Minimum of 24 hours** before your scheduled time. Repeated cancellations will require payment in full or termination of services.

Important Notes

- Mark is a Health Coach, Kalish Method Pracititoner and Level IV C.H.E.K. Trainer. He focuses on improving wellness through Exercise, Lifestyle, Food and Lab-Based Nutrition and Supplementation Programs.
- Please contact the Mark@TheDynamicBody.com if you are not clear on any of our policies or procedures.

I, _____, have read and understood The Dynamic Body Policies and Procedures. Date: _____

Signature_____

Movement by Design, Inc.
Client Charge Authorization

I, (print name)_____authorize Movement by Design, Inc. to bill my credit card as listed below.

Name on Credit Card _____

Credit Card Holder's Billing Address (Where your statement is mailed.)

_____

_____

Credit Card Details

Visa Card # _____ Exp date_____
MasterCard Card # _____ Exp date_____
Amex Card # _____Exp date _____

Last 3 digits (4 for Amex on front) on back of card _____
(found on the back of your credit card on the signature panel)

Client Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Authorization

_____ _____
Card Holder's Signature Today's Date

_____ _____
Patient's Signature Today's Date

This authorization may be revoked at any time when the following stipulations have been performed.

1. Patient has already made new financial agreement that has been signed and dated or card holder/patient has submitted to our office a written request to revoke the card usage (stop billing credit card in writing signed and dated).
2. Patient's account is paid in full.