

Adventures in Weight Loss
20 Bideford Road,
08-04 Wellington Building,
SINGAPORE 229921

APPLICATION FORM



Today's date:					
ABOUT YOU					
Birth date:		Age:		Sex: <input type="checkbox"/> F <input type="checkbox"/> M	
		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.		
Surname:		First:		Middle:	
Postal Address:					
City / State/ Postcode:					
Country:			Email:		
Home Ph.		Mobile:		Work:	
How did you hear about us?	<input type="checkbox"/> Doctor	<input type="checkbox"/> Internet	<input type="checkbox"/> Advertisement	<input type="checkbox"/> Word of mouth	<input type="checkbox"/> Other
If you heard about us from a friend, please let us know their details so that we can thank them.					

YOUR LIFESTYLE					
Present Weight:		kgs		OFFICE USE ONLY	
Height:		cm		BMI:	
Build:	<input type="checkbox"/> Small	<input type="checkbox"/> Medium	<input type="checkbox"/> Large	GOAL WEIGHT:	
Do you do any exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If so, please list the type and regularity:					
YOUR MEDICAL HISTORY					
Please indicate any conditions that apply to you:					
Anaemia	Crohn's disease	Hepatitis	Psoriasis		
Bowel – give details below	Depression	High Blood pressure	Reflux		
Cancer – give details below	Diabetes	High blood sugar	Stomach staple/banding		
Candida	Dizziness	Irritable Bowl Syndrome	Thyroid – give details below		
Chronic Fatigue	Gall bladder problem	Low blood pressure	Ulcerative colitis		
Coeliac disease	Gall stones	Low blood sugar	Other		
Constipation	Heart – give details below	Lupus	None		
Details:					
Please list any operations you have had or will have:					
Other Medical Conditions / Illnesses:					
Please list ALL current Medications and Supplements:					
Name and telephone number of your regular doctor:					
YOU AND FOOD					
Allergies: Please indicate any that apply to you					
<input type="checkbox"/> Dairy	<input type="checkbox"/> MSG	<input type="checkbox"/> Nuts	<input type="checkbox"/> Shellfish	<input type="checkbox"/> Metabisulphite	<input type="checkbox"/> None
Are you Lactose Intolerant? <input type="checkbox"/> Yes <input type="checkbox"/> No					

If so, which of these can you NOT eat? Cheese Milk Yogurt Other _____

Please list any foods you CANNOT eat:

Are there any other details that you would like to bring to the attention of our medical team?

PAYMENT DETAILS

I would like to pay by: Cash / EFTPOS Cheque (made out to Adventures in Weight Loss) Credit Card
 VISA Mastercard

Credit Card No. _____ **Exp:** _____

Cardholder's Name: _____

Cardholder's Signature: _____ PAID

AGREEMENT

I understand and agree that, based on the information provided by me on this (and any other provided) form, Adventures in Weight Loss (S.E.A.) LLP. ("AWL") will provide an eating program based on my individualized needs.

- The information I have provided is accurate and complete, I have included **all** medical conditions and treatments/drugs etc that I may be taking. Further I grant permission for AWL to receive my blood test results and use them in formulating my personalised plan.
- The eating program provided to me is designed and recommended by Dr. J.B. Ryan of J.B. Ryan Medical Pty Ltd, an Australian based Medical Doctor with more than 30 years experience.
- As the program is designed for me alone I understand that sharing this program with others, will not achieve the same results for them and could possibly harm their health.
- All personal information shared with AWL will be kept confidential and not shared or provided to others.
- I understand that everyone will lose weight at different rates so that I might lose weight at a faster or slower rate than others.
- AWL recommends I consult my personal physician before drastically changing my eating habits or beginning any diets or exercise programs.
- I am not currently pregnant and do not plan on becoming pregnant during the course of the program.
- I confirm that I have discussed the program with _____ who has answered all my questions to my satisfaction and I fully understand the benefits and potential side-effects that can result from the program.
- I agree to follow the AWL program EXACTLY and to also make sure I have the follow up blood tests on the appropriate dates so that my plan can be adjusted as I progress for maximum results.
- That upon signing the program application form I am responsible for all costs of the program with no refunds available. The only exception will be that should Dr Ryan decide, after reviewing my blood test results, that I am not suited for this program, I will receive a refund of all money paid, minus the actual cost incurred by AWL to receive and review my blood test results and the information contained in my Application and this Agreement.

Signature: _____

Date: _____

