Stimulock System
Homeopathic Weight Loss

HEALTH CONSULTATION FORM

Date

Name | Sex | Age | Birthdate

Street Address

City | State | Zip

Email Address | Phone

How did you hear about the Stimulock System?

Height | Weight | Goal Weight

Occupation | Daily Physical Activity: (low, moderate, or high)

FEMALES: Are you nursing, pregnant, or think you might be pregnant?

Are you currently taking any prescribed medications? If so, please list.

Are you currently taking vitamins and/or supplements? If so, please list.

Do you have any current health concerns? If so, please explain.

Do you have any known food allergies? If so, please list.

What previous diet programs have you tried in the past 5 years?

How would you describe your diet history? (Chronic dieter, Occasional dieter, Never seriously dieted)

Money Back Guarantee
If you do not lose significant weight during the first 10 days of following the Stimulock System, just return the bottle and your complete food journal to receive a refund minus any shipping charges. If at any time you experience delays in weight loss, gain weight, or have any questions or concerns, please contact your Stimulock practitioner. We want you to get your health and confidence back, feel better, and lose the weight you want to lose.

I have read and understand the conditions of the money back guarantee.

Client Signature | Date

Qty | **Payment Type**