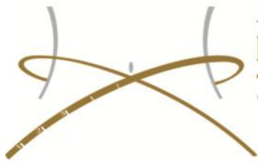

TEAM MEMBER PROFILE

DATE

CONTACT INFORMATION

Name:		
Address:		
City:	State:	Zip:
Primary Phone #: ( )	Secondary Phone #: ( )	
E-mail Address:		

GOALS

Do you have any health-related goals (i.e. lower blood pressure, etc.)? ☐ Yes ☐ No

If yes, please list:

Current Weight:	
Ideal Weight:	
12 WEEK Weight Loss Goal:	
TOTAL Weight Loss Goal:	

PERSONAL DATA

	DAY 1	END OF WEEK 4	LOSS (From Day 1)	END OF WEEK 8	LOSS (From Day 1)	END OF WEEK 12	TOTAL LOSS (From Day 1)
Age:							
Height:							
Weight:							
BMI:							
Waist:							
Hip:							
Thigh:							
Calf:							
Chest:							
Arm:							
Neck:							

MEDICAL ACKNOWLEDGEMENT

The **"Shrink Your Body, Grow Your Business"** Weight Loss Challenge utilizing the Xocai™ High-Antioxidant Weight Loss System does not replace the advice, diagnosis, or treatment plan of one's health care provider. Our purpose is to provide information on healthy lifestyle management and weight management with the intended desire to bring improvement to one's health. We advise you to seek the consent of your health care provider prior to starting this or any weight management program and to always seek the proper medical advice regarding any questions or ailments. By signing below, I indicate that I understand and agree to above.

Signature: Date: