Weight Loss History

Name: _____ Date of Birth:_____ Age:___ Date:_____

Name that you prefer to be called:_____

Address:_____
(Street #) *(City)* *(State)* *(Zip)*

Home Phone:_____ Cell Phone:_____ Sex: M/F

Email:_____ Who is your Physician:_____

Where do you work?_____

Name/# Emergency Contact_____

Dietary & Exercise History

What weight loss programs/techniques/diets have you tried?_____

What was your weight when you graduated high school?_____

What do you attribute your weight gain to?_____

Do you exercise? What type? How often?_____

Do you eat a balanced & healthy diet? Y/N

Do you eat 3 meals/day? Y/N Do you graze throughout the day? Y/N

Are you a night time Eater? Y/N Are you a binge eater? Y/N

Do you skip meals? Y/N Do you eat before you sleep? Y/N

Why do you want to lose weight?_____

How Did you Hear about our Weight Loss Program?

☐ *Already a Client* ☐ *Radio Ad* ☐ *Referred By:*_____

☐ *Billboard* ☐ *Website*

☐ Newspaper Ad ☐ *Walk-in/Sign*