

HEALTH & LIFESTYLE QUESTIONNAIRE



Please provide the following information to assist us in determining your eligibility for our programs and accessing your needs for long term weight loss success. Please answer all questions to the best of your ability.

All information is strictly confidential

Today's Date: ___/___/___

Name _____ Preferred Cell Phone# _____

Email _____

Street Address _____ City, State _____ Zip _____

Age _____ Height _____ Date of Birth ___/___/___

How did you hear about us? _____

Medication(s)/Vitamin Supplements and dosage you are currently taking:

Do you have any known allergies (medication/food/environmental, etc.)

<i>Do any of the following apply?</i>	YES	NO	If yes, CURRENT?
Kidney disease requiring protein restriction	___	___	_____
Pregnant or planning to become pregnant	___	___	_____
Breastfeeding	___	___	_____
Pre-Diabetes	___	___	_____
Type II Diabetes	___	___	_____
Insulin Dependent Diabetes	___	___	_____
Hypertension (High Blood Pressure)	___	___	_____
High Cholesterol	___	___	_____
Uric acid kidney stone or Gout	___	___	_____
Inflammatory bowel disease	___	___	_____
Cancer	___	___	_____
Drug or alcohol addiction	___	___	_____
Pacemaker	___	___	_____

1. Please list the most important reason(s) you are ready to start losing weight **NOW**:
(Example: Health Condition, Special Event, Dr Recommended, Family History, Overall Wellness, Reduce or Avoid Medication, etc)

2. How much do you currently weigh? _____ How much do you want to lose? _____

3. Do you take time to plan/cook your meals? Yes ___ No ___
Or do you prefer fast food? Yes ___ No ___
Or do you tend to skip meals? Yes ___ No ___

4. What, if anything, have you tried previously to lose weight? What difficulties did you face?
What did you love about it? What did you not like about it?

5. Please list what you consider to be the #1 reason you have difficulty losing weight:

6. Do you suffer from Seasonal Affective Disorder (SAD) or struggle with your mood and/or cravings when the sun is not out? Yes ___ No ___

7. Are you interested in learning about our new **Wellness Treatments** that help burn extra calories, assist in the detox process, improve mood and concentration, and keep your lymphatic system moving while you burn fat? Yes ___ No ___

8. Please list what you ate yesterday and **and the time of day:**

Breakfast _____	Lunch _____	Dinner _____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ *Who knows! I just graze all the time!*

9. Please list the typical snacks, beverages & desserts you consume weekly:

_____	_____	_____
_____	_____	_____

Signature _____