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Name			**Age**	**Today's date**
Address			**Phone**	
Email address				**Date of birth**
Weight	**Height**	**Physician**		
What is your goal (weight loss or other health goal)?				
Many people have been able to lose weight permanently with diet and exercise. Would you like to learn more about this? ☐Yes ☐No				
Is it difficult to afford the food, medications, and other things that you need to care for yourself? ☐No ☐Sometimes ☐ Frequently Please explain:				
Do you smoke or drink alcohol? ☐Yes ☐No If yes, please describe.				
Do you have a stressful lifestyle? ☐Yes ☐No If yes, please describe.				
Do you have any allergies? ☐Yes ☐No If yes, please describe.				
How ready are you to put the effort into losing weight? ☐Not at all ☐I'm thinking about it ☐I'm ready for it ☐I'm already doing it ☐Weight is not a concern				
How ready are you to put the effort into exercising? ☐Not at all ☐I'm thinking about it ☐I'm ready for it ☐I'm already doing it				
Do you have any limitations to exercise? ☐Yes ☐No If yes, please describe.				
Difficulty with ☐Hearing ☐Seeing ☐Reading ☐Speaking ☐Physical ☐Psychological ☐English ☐None Please explain:				
How would you describe your overall health? ☐Excellent ☐Good ☐Fair ☐Poor		**Do you feel rested when you wake up?** ☐Yes ☐No		
List any health conditions that you are <u>currently being treated for or have been treated for in the past</u>, e.g. high cholesterol, high blood pressure, cancer, hernia, thyroid, auto-immune, etc.				

Please list medications that you take including prescription, over-the-counter, herbal remedies, and vitamins (you may attach a separate list)

Medication name	Dose/frequency	Medication name	Dose/frequency
1.		5.	
2.		6.	
3.		7.	
4.		8.	