

Full name		Birthdate	
Food allergies			
Why are you seeking a weight loss program?			
What lifestyle changes will you need to make to have success in your weight loss journey?			
How do you see yourself benefiting from successful weight loss?			

DESCRIBE A TYPICAL 24-HOUR DAY OF FOOD INTAKE

Breakfast		Mid-morning snack	
Lunch		Mid-afternoon snack	
Dinner		Bedtime snack	

AREAS THAT AFFECT YOUR WEIGHT

If you answer YES – Please explain in space provided.

Occupational (working around food / no time for lunch)	YES / NO	
Sleep	YES / NO	
Travel	YES / NO	
Household (family / obligations / schedule)	YES / NO	
Shopping or cooking	YES / NO	
Meals eaten away from home	YES / NO	
Additional Information:		

GROCERIES: I GET MY GROCERIES AT THE:
(PLEASE CHECK ALL THAT APPLY)

Grocery store		Convenience store	
Farmers market		Other:	
How many times per month do you shop for groceries?			
What are the top 2 items you must have when you shop for groceries?			

**DIET HISTORY: PLEASE ENTER INFORMATION ON WEIGHT LOSS PROGRAMS
YOU HAVE ATTEMPTED PREVIOUSLY**

TYPES OF DIET PROGRAM OR WEIGHT LOSS METHODS	DATE INITIATED	DATE COMPLETE	WEIGHT LOST	WEIGHT REGAINED
Acupuncture				
Atkins diets				
Bariatric (gastric) surgery				
Diet pills – over-the-counter				
Diet pills - prescription				
Diet shots – HCG, B-12, diuretics				
Hypnosis				
Jenny Craig / L.A. Weight Loss / NutriSystem				
Keto / Paleo				
Mayo Clinic diet				
South Beach diet				
Trim Healthy Mama				
Weight loss program directed by a doctor				
Weight Watchers				
Whole 30				
Zone Diet				
Other:				
Other:				