

**WEIGHT LOSS HEALTH ASSESMENT**

Name:

Date:

Address:

Phone:

Email:

DOB:

How did you hear about us?

Describe your overall health:

Describe WHY you are interested in getting healthy:

Have you tried to lose weight before? If so, what was the most difficult part?

What is your goal weight?

Other goals?

Eating habits:

How many meals do you eat a day?  How many snacks do you eat a day?

How many times a week do you eat out?  When is first/last meal of day?

Hydration:

How much water do you drink each day?

How much other beverages? Coffee  Soda  Tea  Alcohol

Motion:

Rate your energy level (Scale 1-10):

Do you exercise?  Physically active?

Are there things you can't do that you would like to be able to do?

Stress:

How would you rate your stress level? (Scale 1-10):

Occupation:  Do you enjoy what you do?