



Client name: _____ ID# _____
 Process date: _____ Self-adjust: _____
 User name: _____ Password: _____

Address: _____
 City: _____ State: _____ Zip Code: _____
 Best Time: _____ Time Zone: _____
 Phone (work): _____ Phone (home): _____
 Email (work): _____ Email (home): _____
 Occupation: _____ Hours: _____

Exercise: _____
 Frequency: daily 3-5 days/wk 1-2 days/wk None

Medications:

Allergies: None Soy Other: _____

How did you hear about Take Shape For Life? _____

WEIGHT-LOSS GOALS

Current Weight: _____ Height: _____ BMI: _____
 How much weight would you like to lose? _____ pounds

Why do you want to lose weight?
 1. _____
 2. _____
 3. _____

Which other weight-loss methods have you tried?

Plan/diet	Result
_____	_____
_____	_____
_____	_____

For you personally, what is the most difficult thing about losing weight?

Is your family aware that you're starting this program? Yes No

On a scale of 1 (*not at all*) to 10 (*very*), how motivated do you feel today? _____

Do you know of anyone who might want to start this program with you?

