



Please PRINT All Information

Name: _____ DOB: _____ Age: _____ Sex: M F
Address: _____ City: _____ Zip: _____
Home Phone: _____ Work Phone: _____ May we call you at work? Y N
Occupation: _____ Work Hours: _____
Email Address: _____ Preferred Language: _____

Weight History:

Height: _____ Weight: _____ Goal Weight: _____ Weight one year ago: _____
If overweight, how many years? _____
Other weight loss methods/programs that you have used in the past: _____

Which ones were successful? _____

Have you ever seen a Registered Dietitian for weight counseling? Y N

If so, how long ago? _____

What has prompted you to lose weight now? _____

Exercise History:

Type(s) of exercise you do: _____

How many times do you exercise a week? _____

For how long do you exercise each time? _____

How intense is your exercise? Light Moderate Strenuous

