



Thank you for completing this form in an honest and accurate fashion. The information you provide us greatly facilitates our assessment of your profile.

Name of Client: \_\_\_\_\_

Address \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Email Address \_\_\_\_\_

Birthdate: day/month/year \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Gender: Male \_\_\_ Female \_\_\_

**1. Medical History:**

*Do you have any of the following conditions? Please check all that apply.*

Heart condition	_____	Lung disease	_____
Heart attack	_____	Bone or joint problems	_____
High blood pressure	_____	Injuries to back	_____
Angina	_____	Varicose veins	_____
High cholesterol	_____	Epilepsy	_____
Stroke	_____	Gout	_____
Diabetes	_____	Other, please specify	_____
Depression/Anxiety	_____	Trouble Sleeping/Insomnia	_____
		Sleep Apnea	_____

**\*\*If you have kidney disease and/ or are on dialysis this program is not appropriate for you.\*\***

**2. Present symptoms:**

*a) Please check if you recently had any of the following symptoms while at rest.*

Chest pain/discomfort	_____	Arthritis/swollen joints	_____
Back pain	_____	Lightheadedness or fainting	_____
Shortness of breath	_____	Heart palpitations	_____
Cough on exertion	_____	Other	_____
Coughing of blood	_____	Please specify _____	_____

*b) Please check if you recently had any of the following symptoms during exertion, or following exertion?*

Chest pain/discomfort	_____	Arthritis/swollen joints	_____
Back pain	_____	Lightheadedness or fainting	_____
Shortness of breath	_____	Heart palpitations	_____
Cough on exertion	_____	Other	_____
Coughing of blood	_____	Please specify _____	_____

3. Do you work: (please circle one) 9 – 5 \_\_\_\_\_ Shifts \_\_\_\_\_ No \_\_\_\_\_  
Other \_\_\_\_\_

4. Have you had previous diet instruction? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what were you taught? \_\_\_\_\_

By whom/group: \_\_\_\_\_

When: \_\_\_\_\_

5. Are you vegetarian \_\_\_\_\_ lactose intolerant \_\_\_\_\_ other \_\_\_\_\_

6. How often do you eat away from your home? (days per week)

\_\_\_\_\_ 0-1 \_\_\_\_\_ 2-3 \_\_\_\_\_ 4-5 \_\_\_\_\_ 6 or more

7. Are you currently taking any vitamins/minerals, protein powder, protein bars, herbal supplements, etc? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list the names of product and doses you take:

\_\_\_\_\_  
\_\_\_\_\_

8. Please list your current medications and doses:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. List any food allergies or intolerances:

\_\_\_\_\_

10. Activity:

a) How often do you exercise now? (times per week)

\_\_\_\_\_ 0-1 \_\_\_\_\_ 2-3 \_\_\_\_\_ 4-5 \_\_\_\_\_ 6-7

b) What is the duration of each exercise session? (minutes per day)

\_\_\_\_\_ less than 30 \_\_\_\_\_ 30-60 \_\_\_\_\_ greater than 60

c) What is your usual form of exercise?

\_\_\_\_\_

d) Does it hurt when you exercise? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, where \_\_\_\_\_

**11. Have you used any tobacco products or smoked cigarettes within the last 6 months?**

Yes \_\_\_\_ No \_\_\_\_ Quit Date: \_\_\_\_\_

**12. Who influenced you to register for the program? (please check all that apply)**

- Myself
- My family/friends
- My Doctor
- Other \_\_\_\_\_

**13. What barriers do you find most challenging in managing your weight?**

---

---

**14. What do you need the most help with from the program?**

---

---

**15. Are you ready for intense lifestyle changes to be part of your weight management? Please circle only one choice.**

strongly agree    agree    disagree    strongly disagree

a) Please explain your answer circled above.

---

---

**16. How much support do you have from family and/or friends?  
Please circle only one choice.**

0                      1                      2                      3                      4                      5  
No support                      some support                      strong support

**17. How often do you struggle with binge eating (days per week)?**

\_\_\_\_ 0-1    \_\_\_\_ 2-3    \_\_\_\_ 4-5    \_\_\_\_ 6 or more

**18. What are your weight management goals?**

---

---

**19. In what ways do you feel the program can help you meet your goals? Please provide as much detail as you can.**

---

---

---

Thank you for completing our questionnaire. We appreciate your time.

**Signature:** \_\_\_\_\_

**Please print:** \_\_\_\_\_