Take Shape For Life. Fueled by Medifast

Client Profile

First name: _____ Last name: _____

Process date: Not App _____ ID#: Not App _____

Date: _____ Self-adjust: Not App _____

User Name: Not App _____ Password: Not App _____

Address: _____

City: _____ State: _____ Zip code: _____

Best time to contact: _____ Time zone: _____

Phone (primary): _____ Phone (secondary): _____

Email (primary): _____ Email (secondary): _____

Occupation: _____ Work hours: _____

Sex: ❑ Male ❑ Female Age: _____ Birthdate: _____

How did you hear about Take Shape For Life? _____

WEIGHT-LOSS GOALS

What is your motivation for starting the program? _____

Are you interested in creating long term health or simply losing weight? _____

How much weight would you like to lose? _____ pounds

Current weight: _____ Height: _____ BMI: _____

Goal weight: _____ Goal BMI (At least 18.5) : _____

What is the most difficult thing for you about losing weight? _____

Current physical activity: _____

Frequency: ❑ Daily ❑ 3-5 days/wk ❑ 1-2 days/wk ❑ Never Duration: ❑ At least 30 minutes ❑ More than 45 minutes

Sleep (hours per night): _____ Work (hours per day) : _____

Rate your current motivation to lose weight and gain health on a scale of 1 to 10. (10=Very Motivated) _____

Who can support your decision and help you with your goals? _____

Whom do you know who might also be interested in Optimal Health? _____

WHICH PROGRAM IS RIGHT FOR YOU?

Check the boxes that apply. If "yes" to any of these, refer to the Client Profile Reference Sheet

❑ Diabetes (Type I or Type II - circle one) ❑ Gout ❑ Age 13-18 ❑ Age 65 or older ❑ Nursing Mothers

❑ Serious Illness (cancer, liver disease, recent heart attack)

Review Client Profile Reference Sheet with them and note any issues: _____

_____

Do you take these medications? ❑ Coumadin/Warfarin ❑ Thyroid medications

Do you have any food allergies? ❑ None ❑ Food Allergy : _____

Is there anything else you would like to share that may help me to help you? _____

_____