12-Week, GLP-1 Mind Body Transformation

INITIAL CONSULTATION/APPLICANT QUESTIONNAIRE:

Date: _____/_____/_____

Name:_____

Age:_____ Height:_____' _____" Weight:_____# BMI:_____

Email:_____

GENERAL INFORMATION:

How much weight do you want to lose?_____

What do you hope to accomplish from this program?_____
_____

Do you currently take any Vitamins or Supplements? ☐ YES ☐ NO

If yes, please list:_____

Do you currently take any OTC or Prescription Medications? ☐ YES ☐ NO

If yes, please list:_____

Personal Health History:_____

PHYSICAL ACTIVITY:

Are you currently exercising? ☐ YES ☐ NO

How frequently do you exercise? _____Days/Week _____Minutes/Day

What do you do for exercise?_____

List any exercise limitations:_____

DIETARY HABITS:

How would you rate your diet? ☐ POOR ☐ SO SO ☐ GOOD ☐ EXCELLENT

Explain:_____

Have your food habits changed within the past couple months? ☐ YES ☐ NO

If yes, please explain:_____

Any food allergies:_____

Have you ever been on a diet before? ☐ YES ☐ NO

If so, what diets?_____

How many meals do you eat per day?_____

How many bowel movements do you have per day?_____

Approximate time you eat: Breakfast_____ Lunch_____ Dinner_____

Are you a snacker? ☐ YES ☐ NO

What snacks do you consume most often? (Be specific)_____
_____

What time do you eat your last meal or snack?_____

How often do you eat fast food or go to a restaurant? _____/month _____/week

LIFESTYLE HABITS:

Do you smoke? ☐ YES ☐ NO If yes, packs per day?_____

Do you drink alcohol? ☐ YES ☐ NO If yes, drinks per day?_____

How many drinks in one sitting? _____
(1 drink = 12 oz. Beer, 5 oz. Wine, or 1 oz. liquor)

How much plain water do you drink per day?_____ glasses, or _____ oz.

What other beverages do you drink regularly?

☐ Milk ☐ Fruit Juice ☐ Soda ☐ Coffee/Tea ☐ Sports Drinks ☐ Energy Drinks

☐ Vegetable Juice ☐ Other:_____

How many hours of sleep do you get per night, on average?_____

PERSONAL ASSESSMENT OF WEIGHT-RELATED WELLNESS STATUS:

On a scale of 1 – 10, (1 = Very Low, 10 = Very High) please circle your score on the following:

Stress:	1	2	3	4	5	6	7	8	9	10
Daily Energy:	1	2	3	4	5	6	7	8	9	10
Flexibility:	1	2	3	4	5	6	7	8	9	10
Sleep Quality:	1	2	3	4	5	6	7	8	9	10
Gut Health:	1	2	3	4	5	6	7	8	9	10
Brain Fog Level:	1	2	3	4	5	6	7	8	9	10
Short Term Memory:	1	2	3	4	5	6	7	8	9	10
Attention Span:	1	2	3	4	5	6	7	8	9	10
Feeling Hungry:	1	2	3	4	5	6	7	8	9	10
Food Cravings:	1	2	3	4	5	6	7	8	9	10

Is there any other area of your life physically that you would like to improve?_____

_____