



Diet and Exercise History

Name: _____ Date: _____

Address: _____

Telephone Number: _____ Mobile Phone Number: _____

Estimated Current Weight: _____ Goal Weight: _____

What is the main reason for your desire to lose weight?

Weight and Dieting History:

At what age did you first become overweight? _____

Tell us about a couple of diets that have helped you lose weight in the past. Leave blank if you have never followed a diet before.

Name of Diet: _____ Weight Loss: _____

What did you like about this diet? _____

What did you not like about this diet? _____

Name of Diet: _____ Weight Loss: _____

What did you like about this diet? _____

What did you not like about this diet? _____

Eating and exercise habits (mark all that apply):

- I eat when I am under stress
- I am not hungry when I am under stress
- I eat when I am happy
- I eat when I am sad
- I eat three good meals a day and few snacks in between
- I skip big meals and would rather snack throughout the day

- I like to exercise
- I do not like to exercise
- I exercise often
- I do not exercise often
- I rarely eat out
- I eat out often

Weight Loss Medication History:

Have you taken prescription diet pills before? Yes No

If yes, what type? _____

Did you experience negative side effects? Yes No

If yes, what type? _____

What is your biggest concern about this diet program?

Treatment History:

Please mark each of the conditions for which you are currently being treated or have been treated for in the past:

- Diabetes
- Eating Disorders
- Mental Illness
- Hypertension
- Thyroid Disease
- Drug Abuse
- Alcohol Abuse
- Gastrointestinal Problems
- Glaucoma

List all current medications and supplements that you are taking:

Allergies: Are you allergic to Sulfa? Yes No