



REGISTRATION FORM

(Please Print)

Today's date:				SSN:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Height:	Weight:	Desired Weight:			Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
WEIGHT LOSS GOALS							
How much weight would you like to lose? _____ lbs.							
Why do you want to lose weight? (I need 3 reasons)							
1.							
2.							
3.							
BACKGROUND QUESTIONS							
Have you tried other diets?					<input type="checkbox"/> Yes		<input type="checkbox"/> No
How did you do?							
What do you find most difficult when losing weight?							
Is your family aware that you are starting this program?					<input type="checkbox"/> Yes		<input type="checkbox"/> No
Can you count on them to be helpful and supportive?					<input type="checkbox"/> Yes		<input type="checkbox"/> No
Do you have supportive friends and/or co-workers?					<input type="checkbox"/> Yes		<input type="checkbox"/> No
Do you know of anyone who might want to start this program with you?					<input type="checkbox"/> Yes		<input type="checkbox"/> No
Can you eat every three hours?					<input type="checkbox"/> Yes		<input type="checkbox"/> No

HEALTH QUESTIONS

Rate questions on a scale of 1 to 5.

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
	1	2	3	4	5
How motivated are you to succeed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How healthy do you feel?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How would you rate your stress level?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How many hours per day you work?					
How many hours of sleep do you get per night?					
Physical Activity Level:	<input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily				
Medications: Diuretics ("water pills") Blood Sugar Lowering Medication (i.e. insulin, oral hypoglycemics)	<input type="checkbox"/> Blood Thinners <input type="checkbox"/> Lithium <input type="checkbox"/> Thyroid Medications <input type="checkbox"/> Steroids <input type="checkbox"/> Other:				
Medical Conditions:	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Type I Diabetes <input type="checkbox"/> Type II Diabetes <input type="checkbox"/> Pregnant or Breast Feeding <input type="checkbox"/> Other:				
Food Allergies:					
Is there anything else you would like to share that may help me to help you get started?					