

HEALTH SURVEY

PERSONAL DATA

Last Name: _____ First Name: _____

Age: _____ Birthday: _____ E-mail: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Work: _____

Best day & Time to call _____ Height: _____ Current Weight: _____

ABOUT YOUR DIET

How much weight do you want to lose? _____ lbs

What other programs/ products have you tried in the past? _____

Why do you feel that these other program(s) did not work? _____

Do you have cellulite that you want to get rid of? _____ Yes _____ No

Do you eat three meals a day? _____ Yes _____ No

If no, which meal do you skip? _____

Do you have a problem with snacking? _____ Yes _____ No

If yes, at what time of the day or evening is hardest to control? _____

What is your favorite snack? _____

Where do you carry most of your unwanted weight? _____

Do you take vitamins or any type of nutritional supplement? _____ Yes _____ No

How many glasses of water do you drink daily? _____

Do you eat out? _____ Yes _____ No How often? _____

Where is your energy level, on a scale of 1 to 10? (1: Very Low; 10: Very High) _____

Are you currently taking any prescription medication? _____ Yes _____ No

If yes, for what? _____