

WELLNESS SURVEY

Last Name _____ First Name _____ Date _____

Age _____ Birthday _____ E-mail _____

Address _____ City _____ State _____ Zip Code _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Best day & time to call: _____ How did you hear about us? _____

Do you want to... Lose weight? _____ Gain weight? _____ Have more energy? _____

Do you eat three meals a day? Yes _____ No _____ If no, which meal do you skip? _____

Do you eat a variety of Healthy foods from the basic food groups every day? Yes _____ No _____ Sometimes _____

Do you think you get 100% of the daily nutrition needed for good health? Yes _____ No _____ Sometimes _____

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

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

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

On a scale from 1 to 10, where is your energy level? (1: Very Low, 10: Very High) _____

Do you experience a loss of energy during the day? Yes _____ No _____ What time? _____

Which of these words best describes your own lifestyle? Calm _____ Active _____ Stressed _____

Do you have any health issues we need to know about? Yes _____ No _____

If so, what _____

Date of Body Analysis _____
Height _____ Weight _____
Lean Body Mass _____
% Body Fat _____
Target Weight _____
R.M.R _____
Calorie Intake for Weight Loss _____
Protein Range _____

Office Use Only
Input: HBM _____ (initials of coach)
Cust ID# _____
Outlook <input type="checkbox"/>
Emailed: _____

Would you like to refer someone?

Name _____ Phone# _____

Name _____ Phone# _____

Name _____ Phone# _____

Name _____ Phone# _____

Name _____ Phone# _____

