Transformer's Consult Profile

Name: _____ Date: _____
Address: _____ Date of Birth: _____
_____ Email: _____

Marital Status: _____ Spouse Name: _____ No of Children: _____
Cell: _____ Wk No.: _____
Company Name: _____ Occupation: _____
Company Address: _____ How did you hear about us?: _____
_____

Height: _____ Current Weight: _____ Goal Weight: _____
How motivated are you to lose weight right now on scale of 1 to 10, ten being like yesterday? _____
What foods do you crave the most?: _____
What have you tried in the past to lose weight?: _____
What did you LIKE MOST about that experience? _____
_____

What did you LIKE LEAST about that experience? _____
_____
How many times a day do you eat? _____ Do you skip meals? _____ If yes, which meal?: _____
How many bowel movements per day? _____ Do you like to drink water? _____. Coffee? _____
What do you drink most often throughout the day? _____

How many hours of sleep do you get per day on average? _____. Is it hard to fall asleep? _____

When you get to sleep do you stay asleep until it's time to get up? _____ If No, Why? _____
_____

Have you been diagnosed with any of the following? if yes please include **how long & the medication**:
High Blood Pressure **Y or N** Meds: _____
High Cholesterol: **Y or N** – Meds: _____
Diabetes: **Y or N** – Meds?: _____
Fibromyalgia: **Y or N** – Meds? _____
Any other condition **Y or N** w/Meds?: _____
_____

Do you drink alcohol? **Y or N**. If yes, how often **and** how much per day? _____

Do you Smoke? **Y or N**; how many per day_____

How often do you exercise?: _____

What type of exercise you do engage in?: _____

What would you like to accomplish on the lifestyle program?: _____
_____

Fax to: 678-828-5865 OR Email to: KingdomLifestyleCoach@gmail.com