Transformer's New Consult Profile

Name: _____ Date: _____

Address: _____ Date of Birth: _____

_____ Email: _____

Marital Status: _____ Spouse Name: _____ No of Child: _____

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?: _____

Number of bowel movements per day? _____ Do you like to drink water? _____ Coffee? _____

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? High Blood Pressure _____ High Cholesterol: _____

Diabetes: _____ Fibromyalgia: _____ Any other condition?: _____

_____

Do you drink alcohol? _____ If yes, how often and how many a day? _____

Do you Smoke? _____ 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: BodyTransformationsByTrina@gmail.com