Weight Loss Program Intake Form

Client Name: _____ Date of Birth: _____
Gender: [ ] Male [ ] Female [ ] Other

Phone Number: _____ Email: _____

Allergies:
[ ] No known allergies
Please list any known allergies or sensitivities: _____

Medical History:
Please check any conditions you have been diagnosed with:
- [ ] Diabetes
- [ ] High blood pressure
- [ ] Heart disease
- [ ] Thyroid disorders
- [ ] Hormonal imbalances
- [ ] Other (please specify): _____

Please provide details of any existing medical conditions, surgeries, or chronic illnesses not listed above: _____
_____

Medications:
Please provide details of any current medications you are taking:_____
_____

Are you currently under the care of a physician or healthcare professional for any medical conditions? If yes, please provide their contact information:_____

Have you experienced any recent changes in your health, such as significant weight gain/loss, changes in appetite, or unusual fatigue? If yes, please explain:_____

Are you pregnant, planning to become pregnant, or breastfeeding?_____

Do you have any mental health conditions or history of disordered eating that may affect your participation in a weight loss program? If yes, please provide details: _____

Weight Loss Goals:

1. What is your primary goal for the weight loss program? _____

2. How much weight would you like to lose overall? _____

3. What is your desired timeline for achieving your weight loss goals? _____

4. Have you attempted any weight loss programs or diets in the past? If yes, please provide details: _____

5. What are your expectations regarding the support and guidance you would like to receive during the program? _____

Consent:

By signing below, I confirm that the information provided in this form is accurate and complete to the best of my knowledge. I understand that the information collected will be used to develop a personalized weight loss program and will be treated confidentially and I consent to treatment.

Signature: _____ Date: _____