Health Within Wellness Center
WLC Survey

Name____Age______DOB________________
_

Phone(cell)___________________________(home)____________________________(work)____________________
__

Address____city________________state______zip_________
_

email____occupation_______________________________
_

HISTORY

Height?______________________________Current Weight?____

Goal Weight?_______________________Last time you weighed that?______________________________________

What do you think has prevented you from getting to your goal weight? __________________________________

____

List all medications/supplements/OTC products ____

____

____

Do you have any health issues that have caused an increase in weight or inability to lose? ________________

____

What things have you tried? ____Low Fat ____Low Calorie ____Low Carb ____Other

____

____

What has worked for you in the past? ____

____

SUPPORT

Do you have a support person? ____

Weight Loss Buddy? ____

Anyone opposed to you losing weight? ____

How will they feel? ____

How important is it for you to have a support person? ____

What is your biggest fear about starting the program? ____

Why? ____

Are there any upcoming events motivating you to lose weight? ____