

# Weight Loss Consultation Form

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Cell Phone Carrier \_\_\_\_\_

Home Phone \_\_\_\_\_

Email \_\_\_\_\_ Occupation \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Circle One: Single / Married / Divorced / Widowed

Spouse's Name \_\_\_\_\_

Emergency Contact Name and Number \_\_\_\_\_

Who can we thank for referring you to our office \_\_\_\_\_

Current Weight: \_\_\_\_\_ Desired Weight: \_\_\_\_\_

Desired Completion Date: \_\_\_\_\_

On a scale of 1-10 (10=very committed), how committed are you to losing weight? \_\_\_\_\_

Why do you want to lose weight?

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