Weight Loss Registration Form

Personal Information:

Full Name:
_____
____

City: _____State: _____
Zip: _____

Phone Number: _____ Email:
_____

Gender: _____ Date of Birth: _____

Medical History:

Do you have any pre-existing medical conditions?
_____If yes, please specify:
_____
__

_____
_____

_____
_____

_____
_____

Are you currently taking any medications? If yes, please specify:
_____

_____
_____

_____
_____

_____
_____

Have you ever been diagnosed with Type 2 diabetes?
_____

Have you tried any weight loss programs in the past? If yes, please provide details: _____

_____
_____

Weight Loss Goals:

Current Weight: _____ Height: _____ Target Weight: _____

Desired Rate of Weight Loss: _____

What are your main goals for joining our weight loss clinic?
_____

_____
_____

Lifestyle and Dietary Information:
_____

_____
_____

How would you describe your current level of physical activity?
_____

_____
_____

Do you have any dietary restrictions or food allergies? If yes, please specify:
_____

How would you describe your current eating habits?
_____

Additional Information:

How did you hear about our weight loss clinic?

_____

Do you have any specific questions or concerns regarding your weight loss journey?

Please note that the information provided will be kept confidential and used solely for the purpose of assisting you with your weight loss goals. Our team will review your registration form and contact you to schedule a consultation and discuss the next steps.

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