Wellness Questionnaire

1. Have you recently lost or gained weight?	LOST	GAINED
2. What do you do for exercise? How many times per week?		
3. Do you prepare your own meals?	YES	NO
4. How many servings of fruits do you eat per day?		
5. How many servings of vegetables do you eat per day?		
6. What do you snack on?		
7. Do you use any artificial sweeteners?	YES	NO
8. How often do you eat out per week?		
9. Do you skip meals on average?	YES	NO
10. Have you ever used diet pills? PRESCRIPTION **|** OVER THE COUNTER	YES	NO
11. Do you feel you are an emotional eater?	YES	NO
12. Do you cook at home or eat out more often?	HOME	EAT OUT
13. Do you take any multi-vitamins or herbal supplements?	YES	NO
14. Do you feel you are addicted to diet sodas?	YES	NO
15. Have you ever eaten organic foods?	YES	NO
16. Do you smoke?	YES	NO
17. Do you feel you get enough sleep?	YES	NO
18. Have you ever been on a diet program? If so please name a few:	YES	NO
19. Has your primary care doctor suggested weight loss to you?	YES	NO
20. Have you attempted to lose weight on your own?	YES	NO

21. If there is anything you would like us to know or why you consider us for your weight loss goals:

Please be sure to ask about our specials! And thank you for considering us for your weight loss goals