CLIENT DATA

Date: _____

CONFIDENTIAL

Last Name	First Name	MI	Birthday / /	Male □ Female □
Address	City		State	Zip Code
Home Phone ( )	Work Phone ( )	Cell Phone ( )	Fax ( )	
E-mail Address	Occupation	Spouse Name		

Family Physician	Phone ( )		
Address	City	State	Zip Code
**** *If you are planning to submit to your insurance company for reimbursement, please fill out following:*			
Insurance Company	Phone Number	Policy Number	Group ID Number
I hereby grant my permission to contact my physician. Signed: _____		Date: _____	

How were you referred to Healthy Connections?

- ❑ Newspaper
- ❑ Mailing
- ❑ Restart
- ❑ Your Doctor
- ❑ A Friend _____
- ❑ Internet
- ❑ Yellow Pages
- ❑ Weight is unacceptable
- ❑ Outside encouragement
- ❑ Health Issues
- ❑ Other (specify) _____

What do you hope to accomplish with a nutrition program?_____

_____

How can we help you reach that goal? _____

_____

FOR OFFICE USE ONLY

IInitial Weight	Height	Goal Weight	Frame Size □ Small □ Med. □ Large
Wrist	Neck	Upper Chest	Chest
Upper Arms	Ribs	Waist	Abdomen
Hips	Thighs Right Left	Knees Right Left	Calves Right Left