

**DR. JENNIFER MARTIN DC  
WEIGHT LOSS PROGRAM  
CLIENT DATA SHEET**

NAME \_\_\_\_\_ DATE \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 PHONE \_\_\_\_\_ SEX \_\_\_\_\_ AGE \_\_\_\_\_  
 EMAIL \_\_\_\_\_  
 BEST WAY TO CONTACT YOU: (X) PHONE \_\_\_\_\_ TEXT \_\_\_\_\_ EMAIL \_\_\_\_\_  
 OCCUPATION \_\_\_\_\_

<b>BODY</b>			
CURRENT WEIGHT _____	GOAL WEIGHT _____	HEIGHT _____	
EATING HABITS (Mark with X)	EXCELLENT _____	GOOD _____	POOR _____
CURRENT EXERCISE PROGRAM _____			
CONCERNS: (X)	DECREASE PAIN _____	IMPROVE IMMUNITY _____	LOSE WEIGHT _____
	DECREASE INFLAMMATION _____	RESET METABOLISM _____	DETOX _____
CURRENT HEALTH CONDITIONS _____			
PAST MEDICAL HISTORY _____			

<b>MIND</b>	
WHAT DID YOU TRY FOR WEIGHT LOSS IN THE PAST	_____
WHAT DID YOU LIKE ABOUT IT	_____
WHAT DID YOU NOT LIKE ABOUT IT	_____
WHAT ARE YOUR SHORT TERM WEIGHT LOSS GOALS	_____
WHAT ARE YOUR LONG TERM WEIGHT LOSS GOALS	_____

<b>SPIRIT</b>	
HOW DO YOU FEEL ABOUT YOUR IMAGE/HOW YOUR BODY LOOKS	_____
WHAT PARTS WOULD YOU LIKE TO CHANGE	_____
HOW DO YOU FEEL ABOUT YOUR PERSONAL STYLE (CLOTHING, HAIR, MAKEUP, GROOMING)	