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 _____

BODY
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 _____

MIND
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 _____

SPIRIT
HOW TO 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)