LEARN & BURN
WEIGHT LOSS CHALLENGE

Health Survey

Last Name:______________________________First Name:____________________________________

Age:_____________Birthday:_____________________Email:______________________________________

Address:____

City:____________________________________State:___GA___Zip Code:_______________________

Home Phone:____________________________Cell Phone:____________________________________

Height:____________________________Current Weight:______________________________________

How much weight would you like to lose?____

What other programs/products have you tried in the past?___________________________________

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Why do you feel that these program(s) did not work?____

Do you have cellulite that you want to get rid of?______________________________________

Do you eat three (3) meals a day?____

If no, which meal do you skip?____

Do you have a problem with snacking?____

If yes, what time a day is hardest to control?____

What is your favorite snack?____

Where do you carry most of your unwanted weight?____

Do you take vitamins or any type of nutritional supplement?______________________________

How many glasses of water do you drink daily?____

Do you eat out?____________________How many times per week?____________________________

Where is your energy level on a scale from 1 to 10? (1: Very Low; 10: Very High)_________________

Are you currently taking any prescription medication?______________________________________

If yes, for what?____