



Healthy Habits Wellness Clinic

RTA Client Questionnaire

Today's Date _____

Last Name _____ First Name _____

Address _____

City _____ State _____ Zip _____

DOB _____

Email _____

Contact Numbers: Home _____

Cell _____

Please answer the following questions honestly so we can do our best to help you reach your goals.

When did you first begin to gain weight? _____

How many meals do you have daily? _____

What weight loss have you achieved & how long were you able to keep it off? _____

What prevented you from continuing the program? _____

What do you need in a program to help you achieve your desired weight? _____

What challenges have attributed to your weight gain? _____

What is your occupation? _____

What activities do you engage in on a daily basis? _____

Do you have any physical problems associated with your weight? _____

Have you been advised by your family physician to lose weight? _____

If so, what is your Doctor's Name & Address: _____

What made you come back today? _____

Who supports you at home? _____

What important reason, special occasion, or goal date do you have for wanting to lose weight? _____

Can you devote one visit a week? _____

How important is it that you lose weight? _____

What is your current weight? _____

How many pounds would you like to lose? _____

FOR OFFICE USE ONLY

Today's Weight _____ Goal Weight _____ Ideal Weight _____ Needs to Lose _____

Treat Weeks _____ ½ Way Point _____ Goal Date _____ Fat% _____ BMI _____

Waist _____ Age _____ Program Director _____