Kickstart Weight Management

Application

Please complete the information below and return to Katie Massman at the Onsite Clinic.

Full Name: _____ DOB: _____

Occupation: _____ Today's Date: _____

Do you hold BCBS Medical Insurance through the school system or county? Yes No

Email: _____ Phone: _____

General Health

Height: _____ Current Weight: _____ (lbs.) Goal Weight: _____ (lbs.)

Check the following medical conditions you may have been diagnosed with:

- ☐ Cardiovascular/heart disease
- ☐ Stroke
- ☐ High blood pressure
- ☐ Depression/Anxiety
- ☐ High cholesterol
- ☐ High triglycerides
- ☐ Prediabetes
- ☐ Diabetes
- ☐ Metabolic Syndrome
- ☐ Sleep apnea
- ☐ Thyroid condition
- ☐ Renal Disease
- ☐ Other: _____

List all medications and dosages (or attach a separate sheet):

_____

_____

_____

Vitamin, mineral, or other dietary supplements (or include on attached sheet):

_____

_____

List history of surgeries:

_____

_____

What is your motivation to participate in this program and what do you think it will do for you?

_____
_____
_____

Are you willing to attend nutrition counseling at least 4-6 times within 3 months?

- ☐ Yes
- ☐ No

Are you willing to attend nutrition classes (at least 5 out of 6) within 6 weeks?

- ☐ Yes
- ☐ No

What nutrition, exercise or wellness topics would you like to learn about?

_____
_____
_____