INSTITUTE *of* EATING MANAGEMENT

New Client Information

Name:			Date:
Address:			
City:		State:	Zip:
E-mail:	Cell Phone:		Home Phone:
Age:	Birth Date:	Sex: ☐ Female	☐ Male
Height:	Present Weight:	What is the most that you have ever weighed? (not including pregnancy):	
Occupation:			
Were you a previous client? ☐ Yes ☐ No		If so, who did you see:	

If not a previous client, how did you hear about us?

☐ Internet ☐ Facebook ☐ Instagram ☐ Twitter ☐ Other

If you were Referred, by whom:

In case of emergency, notify:

Relation to Client:	Phone:

List any serious medical conditions:

Have you ever been diagnosed as having any of the following?

☐ High Blood Pressure	☐ Diabetes	☐ Hypoglycemia
☐ Ulcers	☐ PCOS	☐ Heart Disease
☐ Irritable Bowel Syndrome	☐ Diverticulitis	☐ Gout
☐ Hypothyroid	☐ Hashimoto	

List any food allergies:

List any current medications: