



Custom Meal Plan and Weight Management Program Forms

Name: _____ DOB: ____/____/____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Primary Email: _____

Emergency Contact: _____ Phone: _____

Personal Profile Information:

Height: _____ Weight: _____ Body fat %: _____

Exercise Information:

Explain in detail what type of resistance training, cardiovascular or sports activities you participate in on average during a 7-day period. **This is important and will help with the accuracy of your individual metabolic profile.**

Exercise/Activity	Minutes	Times/Wk
_____	_____	_____
_____	_____	_____
_____	_____	_____

Your Body Type

Please select the option which best describes your body type:

- Type I:** I can eat anything I want and not gain weight. I have a very hard time gaining weight.
- Type II:** I can lose or gain weight by adjusting my activity level and eating habits.
- Type III:** I find it very hard to lose weight. I gain weight very easily and have to watch everything I eat.

Lifestyle / Professional Activity

How would you rate the activity level of your profession, of what you do during the day (non-exercise related).

- Sedentary Moderately Active Active Very Active

What are your personal health and weight loss goals?

- Weight Loss Maintain Weight Weight Gain Goal weight: _____

Protein Requirements

Please select the option below which best describes your protein requirements:

- Sedentary Adult Exercising Adult Competitive Athlete
 Growing Teenage Athlete Adult Building Muscle Athlete Restricting Calories

Health History and Medical Conditions

Please select any of the conditions that apply to you:

- Heart Disease Anemia Hypoglycemia Liver Disease
 Kidney Disease Diabetes Pancreatic Disease Lactation
 Hypertension Other:

Please describe what you typically eat in a 24 hour period. Be sure to include snacks and beverages, including water. Be sure to show approximate amounts.

Time:	Food / Beverage	Amount	Calories	Carb	Protein	Fat	Fiber

Please list your favorite foods/beverages:

Make a list of foods/beverages that you dislike:

What time do you normally wake up? _____

What time do you normally go to bed at night? _____

Do you smoke? Yes No

If you answered yes, how many per day? _____ How many years? _____

Do you drink alcoholic beverages? Yes No

If yes, what type do you drink? _____

How many per day? _____ How many per week? _____

Are you allergic to any types or kinds of foods? Yes No

If you answered yes, which ones? _____

Have you ever been placed on any type of nutritional program in the past? Yes No

If yes, by whom and what did it consist of? Please explain below.

What were your results?

What do you feel would benefit you the most from this custom meal plan?

Name: (Print Clearly) _____

Signature of Participant: _____ Date: _____

To better serve you, please fill out this questionnaire honestly and accurately. The purpose of this questionnaire is to help identify your specific nutrition needs that will help us pinpoint the best guidelines and recommendations for you.

1. Tell us a little more about your weight loss and wellness goals. How much weight do you ultimately want to lose? _____. What size would you like to get down to? _____.

2. Why is that important to you (what is primary source of motivation for you to achieve this goal)?

3. Are you currently engaged in a physical fitness / exercise program?

If you answered yes, describe the program, how often and how long you are exercising:

4. How many meals/snacks do you currently consume per day?

5. Describe your energy levels throughout the course of the day?

6. What are your biggest struggles with your current eating habits?

7. How many times were you sick last year?

8. Are you taking any vitamins or supplements right now? Yes No

If yes, which ones and why? _____

9. How committed are you to achieving your goal right now on a scale from 1 – 10?

10. What will you continue to miss out on if you *do not* commit and take action to improve your health and achieve your weight loss goal?

Name: (Print Clearly) _____

Signature of Participant: _____ Date: _____

I would like to begin my weight loss / weight management program on: ____ / ____ / ____
(Please allow up to 2 – 3 business days for the development/upload of your custom meal plan)

Program Options (check one):

- 4 Week
- 8 Week
- 12 Week
- Other

Payment Options: (check one):

- Personal Check
- I paid online (via PayPal)
- Payment plan (Credit Card Authorization Form required)

Office Use Only:

Amount Paid: _____

Form of Payment: _____

Balance: _____

Client Agreement and Informed Consent Waiver

1. Cancellation/Missed Sessions Policy: If you cannot make a scheduled follow up nutrition counseling session, please notify your weight loss counselor within 24 hours to avoid forfeit of your session. There are no refunds for cancelled sessions.

2. Money Back Guarantee: We guarantee you will realize significant and tangible results from our services if you adhere to the meal plan and nutrition program we outline for you, or you are entitled to a full refund of your initial program cost. In signing this document, you understand all guarantees are forfeited if you do not attend all scheduled follow-up sessions for your specified program period and fail to document your nutrition intake for the specified program period.

3. Use of Nutritional Supplements: To guarantee safety, we request that you do not use any potentially dangerous "diet" or "fat burning" pills or stimulants of any kind. To ensure optimal results, we offer natural organic based Nutrilite® supplements. To place an order for Nutrilite® supplements and whey protein, contact your fitness coach.

4. Release of results upon program completion: Client results and photos are requested at the completion of your weight management program and may be used for promotional and educational purposes.

I, _____ AGREE TO ALLOW JOE RAMIREZ, CERTIFIED WEIGHT LOSS COUNSELOR AND CERTIFIED WEIGHT MANAGEMENT CONSULTANT, TO DESIGN A WEIGHT MANAGEMENT PROGRAM AND/OR CUSTOM MEAL PLAN FOR ME TO ENHANCE MY HEALTH & FITNESS GOALS. I WILL FOLLOW THAT PROGRAM TO THE BEST OF MY ABILITY AND I WILL NOT HOLD JOE RAMIREZ OR ANY ONE RELATED PERSONS OR PARTIES PERSONALLY LIABLE FOR ANY PROBLEMS, ILLNESSES OR INJURIES THAT MIGHT OCCUR DUE TO A SUDDEN CHANGE IN MY EATING HABITS. I UNDERSTAND THAT JOE RAMIREZ IS NOT A REGISTERED OR LICENSED DIETITIAN, NOR A MEDICAL PRACTITIONER. THIS WEIGHT MANAGEMENT PROGRAM DOES NOT REPLACE THE EXPERT ADVICE OR MEDICAL TREATMENT OF MY OWN PRIVATE DOCTOR. I HAVE GIVEN JOE RAMIREZ ALL NECESSARY INFORMATION ABOUT MYSELF TO PREVENT ANY POSSIBLE COMPLICATIONS.

Name: (Print Clearly) _____

Signature of Participant: _____ Date: _____