CLIENT PROFILE/COMMUNICATION

Check-In Day

Medical Information

• High Blood Pressure • Type 1 Diabetes • Type 2 Diabetes • Thyroid Disease • Heart Disease

• Other _____

Food allergies • Gluten • Soy • Other _____

Your *why:*

☐ Advised to contact Health Care Provider

The program I would recommend is: • 5&1 • 3 & 3 • Other _____

Name: _____ ID#: _____

Address: _____

City/St/Zip: _____

Email: _____

Phone: _____ ❑ Text Other _____ Time Zone: _____

DOB: _____ Height: _____ Beginning Weight: _____ Goal Weight: _____

Assessment Date: _____ Order Date: _____ Arrive Date: _____ Start Date: _____

☐ Lead ☐ Referral _____ ☐ Wellness Credit Done ☐ Other _____

FAT BURN

Day 1 _____

Day 2 _____

Day 3 _____

Day 4 _____

Notes

PREPARE

Action:	Date:	Action:	Date:
❑ # in Cell Phone	_____	❑ FB Support Group	_____
❑ Set up in Email	_____	❑ Support Intro	_____
❑ Welcome Email	_____	❑ Day 1-5 Emails	_____
❑ Kick Off Video	_____	❑ Referral Packet	_____
❑ Kick Off Call	_____	❑ Order Instructions	_____
❑ Before Pictures	_____	❑ _____	_____
❑ Measurements	_____	❑ _____	_____
❑ Community Zoom	_____	❑ Transition Info	_____

COMMUNICATION

Action:	Date:
❑ _____	_____
❑ _____	_____
❑ _____	_____
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