Client Questionnaire

Please fill out the form below. Skip answers that do not apply. Then save file and resend it to us.

Questions	Answers
Name:	
Age:	
Male/Female:	
Job:	
Phone number:	
Email:	
City:	
How did you hear about us?	
Are you interested in **losing weight, getting healthier** or **both** off?	
WEIGHT	
How much do you weigh now?	
What is your goal weight?	
Do your family have weight problems? If yes, who?	
At which age did you first notice you started gaining weight and what occurred (stress or other) just before this?	
Briefly describe what other programs you have tried to lose weight and the results?	
Why do you personally want to get your weight off?	
WHY DO YOU THINK ARE YOU OVERWEIGHT?	
• **Food Intake** (Eat too much, unbalanced, irregular. Emotional or Mindless Eating)	
• **Chemical Imbalance** (Give us the name and why you take Chronic medication. Diabetes? High blood pressure? High Cholesterol? Anti-Depressants?)	

• **Hormonal Imbalance** (Estrogen, Progesterone, Testosterone, Diabetic, Thyroid, Liver)	
Where do you hold your weight **(Top / Bottom / All Over)**	
Do you have Love Handles? Yes / No	
GENERAL	
How is your current willpower **(good / bad / so so)** Why?	
How stubborn is your current ability to lose weight?	
HEALTH	
What **health problems run in the family**?	
Please indicate any abnormal blood test, hormone test, urine test, MRI, etc.	
Describe your **sleep**, both is quantity and quality.	
Describe your **energy** level (include how you feel when you wake up and through the day).	
What's your **digestion** like; bloating, constipation, indigestion, IBS, acid reflux?	
How frequent is your **bowel movements** (per day or per week)?	
Where do you have **pain, inflammation or stiffness**?	
Sinus?	
Hair Loss (describe)?	
Urination issues?	
Cold feet or hands?	
Fluid Retention?	
Any Autoimmune Disease?	
Anxiety?	
Acne?	
Red cheeks?	
Puffy under eyes?	
Loss of eyebrows?	
Skin issues (describe)?	
Allergies?	
Asthma?	
Out of breath climbing up stairs?	

Low sex drive?	
Headaches?	
Varicose veins or spider veins?	
Tell me what types of surgeries did you have (gallbladder removal, appendectomy, thyroid, tonsils)?	
Tell me about any major injuries?	
Tell me about any significant stress events (losses of loved ones, divorce, etc.)?	
HABITS	
Not satisfied after eating a meal/need something sweet after?	
What do you **crave**?	
Stress eater, snack out of boredom?	
How is your current willpower (good, bad or so so)? Why?	
How much **alcohol** do you consume per week?	
Describe your current type of **exercise program** if any?	
Anything else you want to communicate?	
FEMALE ONLY	
Describe your menstrual cycle. If you are in menopause, please describe what your cycle has been in the past **(heavy, cramping, irregular, normal)**	
Do you have Children? Birth weight? Are they overweight now?	
At which age did you first get your period?	
Do you get hot flashes or night sweats?	

Thanks, you got it done! Save this file now and resend it to
support@tenazinternational.co.za
TenaZ will start your evaluation soon. If you have any questions, please call our Diet Hotline at 0861 595959 or call me at 0826486849. Greetings Sanet.