Weight Loss Matters
Re-registration Form

Please check which class you are re-registering for:
□ Tuesdays 12:10-12:50 102 Mining & Minerals Bldg.
□ Tuesdays 5:15-6:15 J524 KY Clinic
□ Thursdays 11-Noon G040 Gill Heart Bldg.

Name _____ Date_____

Wellness ID (SSN): _____ D.O.B. _____

Current weight _____ lbs. Weight loss goal for the next 10 weeks _____ lbs.

Are you physically active? ___ Yes ___ No

If yes: No. of days per week _____ Duration of activity _____

Type of activity _____

Do you think you need a different meal plan? _____ Yes _____ No

If Yes, please tell us why: _____

Please read the five statements listed below. Mark the one (1) statement that best reflects your current status regarding weight loss.

_____ I have not thought about losing weight during the past six months.

_____ I have thought about losing weight during the past six months.

_____ I am prepared to start losing weight within the next month.

_____ I am currently taking action to lose weight.

_____ I have maintained weight loss for the past six months or longer.

Have any of your medication dosages been reduced due to your weight loss?

_____ Yes _____ No _____ I am not taking any medications

If Yes, please specify: _____