PROVIDER CHECK-IN SHEET

Complete this form prior to each of your check-in appointments with your provider. This information will help you track your progress, and also helps determine if your provider needs to make any changes to your medication or lifestyle.

Date: Medication: Titration:

Weight:

BMI:

Body Fat %:

Lean mass:

Nutrition:

Average Daily Calories:

Meals per day:

Hunger Level (1-10):

Water intake (oz per day):

Exercise:

Routine? Yes or No

Days per week:

Cardio: Yes or No

Strength Training: Yes or No

Flexibility: Yes or No

Medication Side Effects:

Mindful eating:

Pace of eating: Fast or Slow

Non-hunger eating? Yes or No

Avoids distractions while eating? Yes or No

Mindset/Self-Care

Hours sleep per night:

Quality of sleep: Good/Average/Poor

Stress Management:

Rate stress (1-10):

Activities for stress management:

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Notes:

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