CHRISTIE CLINIC
transformations
MEDICAL WEIGHT LOSS PROGRAM

Official Entry Form
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(Essay or no more than 500 words).

Why do you want health and vitality in 2014 via the Christie Clinic Transformations Medical Weight Loss program? Feel free to type your essay, so that it is legible.

(attach extra page if necessary)
(Entry form continued)

Name: ______________________________ Phone Number: ____________________

Age: ______ Profession: _______________________________________

Current Weight: _______ Maximum Adult Weight: _____

Have you done a diet before? (please circle) Yes No

Can you tell us why you had success or didn't have success?

____

____

How important on a scale of 1-10 is losing the weight via Transformations to you? ________

Do you have any food allergies? (please circle) Yes No If so, what?

____

What is your typical diet like currently?

Breakfast at ____ A.M.

____

Lunch at ____ A.M. OR P.M.

____

Dinner at _____ P.M.

____

Snacks at _____ A.M. or ____ P.M.

____

Please send in your 1 page story & answers to the question above to:
weightloss@christieclinic.com OR Christie Clinic Transformations Medical Weight Loss Contest, 501 N. Dunlap, Savoy, IL 61874