



**Fidalgo Island Walk-In Clinic**  
Walk-In to Weight Loss Program

**Patient Check-In Form**

Patient name: \_\_\_\_\_ Date: \_\_\_\_\_

E-mail address: \_\_\_\_\_ DOB: \_\_\_\_\_  
*(Confidential, for program purposes only.)*

Diet History: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Exercise History: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please return form to reception when complete. Thank you.