OPTAVIA®

HEALTH ASSESSMENT: INTRODUCTIONS & SETTING EXPECTATIONS FOR MEETING

Note: All text in *'italics'* are meant to be read out-loud to Clients.

NAME: _____ EMAIL: _____

CLIENT ID NUMBER:	PREFERRED METHOD OF CONTACT:	PHONE:

It's great speaking with you today and I'm excited to see if I can assist you with your goals. Before we can determine if one of our Programs is right for you, I'd like to ask you a few questions to learn about you and your health goals. Does that sound good?

STEP 01: AWAKEN

1 *I would love to hear what you would like to accomplish with your health.* (Weight loss, improved sleep, better response to stress, etc.)

2 *What is your main motivation for wanting to make changes to your health?* (Relationships, activities, how you will feel, etc.)

3 *Can you tell me about a time in your life when you were healthier? What has changed between then and now?*

4 *Tell me about your health:*
*Do you have any allergies or medical conditions that could influence which Program we choose?**

***Reminder: We recommend that Clients contact their healthcare provider before starting and throughout their weight loss journey.**

5 *Are you pregnant?* ◯ YES ◯ NO *Are you nursing?* ◯ YES ◯ NO *If yes, how old is your baby?* _____

6 *Are you taking any medications for:*

- ◯ *Diabetes*
- ◯ *High Blood Pressure*
- ◯ *Lithium**
- ◯ *Thyroid†*
- ◯ *Coumadin (Warfarin)‡*
- ◯ *Other medications:*

_____

_____

_____

7 *Do you have the following:*

- ◯ *High Blood Pressure*
- ◯ *Diabetes Type I*
- ◯ *Diabetes Type II*
- ◯ *Gout*
- ◯ *Gluten Intolerance or Sensitivity*
- ◯ *Soy Allergy or Intolerance*
- ◯ *Food Allergies*
- ◯ *Other*

_____

*__Lithium:__ The healthcare provider may wish to adjust frequency of lab work for the Client and monitor.
†__Thyroid Medications:__ The healthcare provider may wish to monitor thyroid hormone levels while the Client is on the Program and adjust medication.
‡__Coumadin (Warfarin):__ The healthcare provider may wish to review food choices, conduct lab work and/or adjust medication.

8 *Now that you've shared some of your current health goals, I want to give you a quick idea of what is possible.*

Share YOUR story (or someone else's).
Take 90 seconds or less to share the pieces of your story or a Client's story that will connect with this person.

Remember: If a Client answers affirmatively to any of the questions to the left, consult the '**Health Assessment Guidelines: OPTAVIA Program Considerations**' page before suggesting a Program.

STEP 02: DAILY ROUTINE & HABITS

SLEEP & ENERGY

*How many hours of sleep do you get in a typical night?*_____
*How would you describe the quality of your sleep?*_____
*On a scale of 1-10, what is your energy level throughout the day?*___

MOTION

*How would you describe the quantity & quality of the activity you do each week?*_____
*How many hours a day do you sit?*_____
How many days a week do you exercise? (0 - 7 days) _____
*What types of physical activity do you enjoy?*_____

MIND

*On a scale of 1-10, how fulfilled are you?*_____
*On a scale of 1-10, how much do you worry?*_____
What area of your life tends to be the biggest stress for you?

_____

*What do you do for work?*_____
*On a scale of 1-10, how much do you enjoy what you do?*_____

FOOD & HYDRATION

*How many meals and snacks do you eat per day?*_____
*When do you eat your first meal of the day?*_____
How many times a week do you eat out? And where? _____

_____

*How many ounces of water do you drink per day?*_____
Do you drink other beverages? Coffee, soda, alcohol, tea, etc.
If so, how often and how much? _____

_____

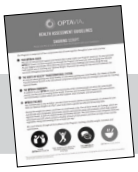
WEIGHT MANAGEMENT

*Are you comfortable sharing your age?*_____
How tall are you? _____
*How much do you currently weigh?*_____
*What would you consider to be a healthy weight for you?*_____
*Have you tried to lose weight in the past?*_____
What has been difficult for you about losing & maintaining weight? _____

SURROUNDINGS

On a scale of 1-10, how healthy would you rate your surroundings? (Does this person have healthy and active friends, supportive family, keep junk food in the house, etc.) _____
Is there anyone in your life who would like to get healthy with you?

Is there anything else you think I should know about your health?



Thank you for sharing, now I'd like to tell you how our Program could help you achieve your goals.

NEXT STEP: Refer to the '**Health Assessment Guidelines**: Sharing Script'

CLIENT TRACKING INFORMATION:

HOW DID WE MEET?	
LEAD	REFERRAL OF:

STARTING WEIGHT:

GENDER:		AGE:	
CURRENT WEIGHT:		CURRENT BMI:	
DESIRED WEIGHT:		DESIRED BMI:	
HEALTHY WEIGHT RANGE:			
HEALTH ASSESSMENT DATE:			
ORDER DATE:		START DATE:	

ADDRESS:	
CITY/STATE/ZIP:	
TIME ZONE:	

COACH CHECKLIST:

- ◯ RECOMMEND TO CLIENTS TO CONSULT THEIR HEALTHCARE PROVIDER BEFORE STARTING ANY **OPTA**VIA PROGRAM.
- ◯ CONFIRM RECEIPT OF CLIENT'S WELCOME EMAIL (BEFORE & AFTER, MEASUREMENTS AND GUIDE).
- ◯ SEND A FRIEND REQUEST VIA FACEBOOK, OR ADD THEM TO A FACEBOOK SUPPORT GROUP AND WELCOME THEM.
- ◯ SEND THE JOURNEY KICK-OFF VIDEO & CONFIRM THE VIDEO WAS VIEWED PRIOR TO HAVING A BRIEF NIGHT BEFORE CONVERSATION.
- ◯ ADD CLIENT TO YOUR NEWSLETTER.
- ◯ SET UP DAILY SUPPORT MESSAGES (VIRTUAL OR TEXT).
- ◯ INVITE TO SUPPORT CALLS.
- ◯ TEACH CLIENT ON HOW TO REFER OTHERS.
- ◯ SEND **OPTA**VIA PREMIER ORDER VIDEO WHEN 7-DAY REMINDER EMAIL COMES.

COACH TIPS:

As your Client begins their journey to optimal wellbeing, they may feel hungry, tired or irritable as their body adjusts to a new way of eating. While adjusting to intake of a lower-calorie level and diet changes, some people may experience temporary lightheadedness, dizziness or gastrointestinal disturbances.

When speaking to your Clients, here are a few additional tips to make the adjustment period easier into fat burning for your Clients.

You can remind them to:

- Stay hydrated with water.*
- Consider choosing a start date when you don't expect any social food-centered events.
- Stay busy.
- Approach their health journey, one day at a time.
- Open up *Your LifeBook*, put your name in it & read the introduction, once in a fat burning state.
- Avoid temptations, and stay focused on your health goals.
- Sip on 1 cup of broth or eat 2 dill pickle spears (as needed in the first few days). **If Client has no sodium restrictions.**
- Wait to start exercising for 2 - 3 weeks on the Optimal Weight 5 & 1 Plan®. **We recommend checking with your doctor before starting any exercise program.**

*We recommend drinking 64 oz. of water each day. Consult with your healthcare provider prior to changing the amount of water you drink as it can affect certain health conditions and medications.

OPTAVIA®

HEALTH ASSESSMENT: CLIENT CHECK-IN TRACKER

Make sure to call your Client during the first week per the schedule below!

REMEMBER TO CONTINUE TO CHECK-IN WITH YOUR CLIENT FROM DAY 7 ONWARD

Please use the following pages to continue your check-ins. Confirm a weekly check-in day. ◯S ◯M ◯T ◯W ◯T ◯F ◯S

Ask them: *Have you shared your success with anyone? Are people asking you about your transformation? When that happens, you can refer those people to me and receive "X" (if you choose to do a referral program on your own to thank people for referrals, please discuss with your Business Coach). Or, because people often prefer to be coached by their friends and family, you may want to consider coaching them yourself. A significant percentage of our Coaches were Clients first who then decided to "pay it forward."*

	DATE	NOTES:
JOURNEY KICK-OFF CHECK-IN		
DAY ONE CHECK-IN		
DAY TWO CHECK-IN		
DAY THREE CHECK-IN		
DAY FOUR CHECK-IN		
DAY SEVEN CHECK-IN		

TIPS FOR WORKING WITH NEW CLIENTS:

1. Place their completed Health Assessment in **Section 2 - 'New Clients'** folder.
2. Make sure you have your weekly check-ins with your New Clients, discuss their Health Assessment with them and make a note of their progress.
3. Set a Client Support day during the week and graduate all Week 1 - Clients to that day's schedule moving forward.
4. Once a Client has been on their Program for one month, move them to **Section 3 - 'Active Clients'** folder.

WEEK 2 CHECK-IN		
CHECK-IN		
WEEK 3 CHECK-IN		
CHECK-IN		
WEEK 4 CHECK-IN		
CHECK-IN		

	DATE	NOTES:
WEEK 5 CHECK-IN		
CHECK-IN		
WEEK 6 CHECK-IN		
CHECK-IN		
WEEK 7 CHECK-IN		
CHECK-IN		
WEEK 8 CHECK-IN		
CHECK-IN		
WEEK 9 CHECK-IN		
CHECK-IN		
WEEK 10 CHECK-IN		
CHECK-IN		
WEEK 11 CHECK-IN		
CHECK-IN		
WEEK 12 CHECK-IN		
CHECK-IN		

CONTINUE CHECK-INS WITH YOUR ACTIVE CLIENTS TO ASSIST THEM ON THEIR JOURNEY THROUGH OUR HABITS OF HEALTH® TRANSFORMATIONAL SYSTEM.