

# TRIM AT HOME™

PO Box 30674 PALM BEACH GARDENS, FL 33420

NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-MAIL: \_\_\_\_\_

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**PLEASE CHOOSE PROGRAM DESIRED**

**TRIM SHAPE UP PROGRAM** - \$40.00 U.S Funds

Complete 4 week self guided program, includes 4 menus, one study guide, recipes & related material. Recommended for individuals only needing to lose about 10 pounds.

**TRIM SLIM DOWN PROGRAM** - \$60.00 U.S Funds

Complete 6 week self guided program, includes 6 menus, Food Use & Shopping Guide, Do's & Don'ts Student Orientation, Trim Option List, Recipes, Personal Weight Chart, 6 Food For Thoughts, and Study Guide.

**TRIM PERSONAL GUIDANCE PROGRAM** - \$75.00 U.S Funds

Complete 8 week program, includes 8 menus, 2 study guides, recipes, related material & features weekly monitoring.

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**INDICATE FORM OF PAYMENT BELOW**

( ) Check / Money Order Enclosed

Charge to: ( ) Master Card ( ) Visa

Cardholder Name: \_\_\_\_\_ Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Billing Address Zip Code: \_\_\_\_\_

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**TO RECEIVE CORRECT MENU SERIES, PLEASE PROVIDE INFORMATION REQUESTED.  
THIS APPLICATION AND ALL QUESTIONS MUST BE COMPLETED IN FULL BEFORE  
MATERIAL CAN BE SENT.**

CURRENT WEIGHT: \_\_\_\_\_ DESIRED WEIGHT: \_\_\_\_\_

Height: \_\_\_\_\_ Feet \_\_\_\_\_ Inches AGE: \_\_\_\_\_ SEX: ( ) Female ( ) Male

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1- Please list all medical problems. Do you have high cholesterol? \_\_\_\_\_

2- What medications, if any do you routinely take? \_\_\_\_\_

3- Are you lactose intolerant or allergic to any foods? Do any foods cause digestive problems? \_\_\_\_\_

4- Will the alcohol restriction on the Trim Program be a problem? \_\_\_\_\_

5- What and how often is any kind of physical activity done? \_\_\_\_\_

6- What other weight loss methods have you tried? Were they successful? \_\_\_\_\_

7- How did you hear about The Trim Weight Control Program? \_\_\_\_\_

8- Where do you feel your weaknesses lie in regard to dieting? \_\_\_\_\_

9- Do you feel you have good eating habits? Do you turn to food in times of stress? \_\_\_\_\_

10- Give a brief history of your weight problem. Are other family members overweight? \_\_\_\_\_

11- Are those close to you supportive of your desire to lose weight? \_\_\_\_\_

12- What made you decide to lose weight? \_\_\_\_\_

"Terms and conditions are those stated on the Trim At Home web site, trimathome.com; In submitting this application form, it is understood that you have read and agree to all said terms and conditions therein stated."

**TRIM WEIGHT CONTROL PROGRAM™**

[www.trimathome.com](http://www.trimathome.com)

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