WEIGHT LOSS QUESTIONNAIRE

Patient Name: _____ Age: _____ Date of Initial Consultation: _____

Height: _____ Current Weight: _____ Goal Weight: _____

How long have you been trying to lose weight? _____

What has been your heaviest weight? _____

When were you that weight? (At what age?) _____

Have you ever stayed the same weight for 10 years of more? YES NO

Are any members of your household overweight? YES NO

If yes, please list the relationship and details _____

_____

_____

What was your motivation for wanting to lose weight? Check all that apply.

- ☐ Don't like the way I look
- ☐ More energy
- ☐ Better work opportunities
- ☐ More mobility
- ☐ Look Better
- ☐ Live longer
- ☐ Reduce medications
- ☐ Upcoming vacation
- ☐ Attend an event
- ☐ Clothes don't fit anymore
- ☐ Improve health
- ☐ Feel better
- ☐ Want to wear smaller size
- ☐ Perform better
- ☐ Feel more confident socially
- ☐ Look more attractive to my partner
- ☐ Want to wear more stylish clothing
- ☐ Other: _____

_____

What dietary problem areas apply to you? Check all that apply.

- ☐ Skipping Meals
- ☐ Craving carbohydrates
- ☐ Large portion sizes
- ☐ Too much alcohol
- ☐ Frequent snacking
- ☐ Binging on food
- ☐ Eating Foods too high in fat
- ☐ Eating too many meals in restaurants
- ☐ Eating for reasons other than hunger
- ☐ Eating before going to bed
- ☐ Making yourself vomit after meals

What weight loss programs have you participated in?

	PROGRAM/PLAN	RESULTS?	LENGTH OF PARTICIPATION?
	WEIGHT WATCHERS		
	JENNY CRAIG		
	SLIM FAST		
	ATKINS		
	SOUTH BEACH		
	LA WEIGHT LOSS		
	NUTRISYSTEMS		
	LINDORA		
	OVEREATERS ANNONYMOUS		
	LIQUID DIETS (EG. OPTIFAST, JUICING)		
	DIET PILLS: MERIDIA, XENICAL		
	DIET PILLS: PHEN-FEN, REDUX		
	OTC DIET PILLS		
	OBESITY SURGERY		
	OTHER: _____		

Have you maintained any weight loss for up to one year on any of these programs? YES NO

What did you learn from these programs regarding your weight? _____

_____

_____

Why did these programs not meet your expectations? What did not work? _____

_____

_____

Please answer the following questions on a scale of 1 – 5.

SCALE: LEAST 1 2 3 4 5 MOST

- ☐ Your level of interest in losing weight is?
- ☐ Are you ready for lifestyle changes to be part of your weight control program?
- ☐ How much support can your family provide?
- ☐ How much support can your friends provide?
- ☐ How confident are you that you can lose weight this time?
- ☐ How confident are you that you can keep the weight off this time?

FOOD ALLERGIES: _____

FOOD DISLIKES: _____

FOODS YOU CRAVE: _____

HEALTH HABITS

On average, how many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

Do you smoke? YES NO If yes, how often? _____

Average stress level: LOW MEDIUM HIGH why? _____

_____

Please check the list below if you eat at the specified times.

	DO YOU…	TYPICAL FOODS CONSUMED DURING EACH SPECIFIED TIME
	EAT BREAKFAST	
	EAT LUNCH	
	EAT DINNER	
	EAT BETWEEN MEALS	
	EAT AT NIGHT	
	EAT WHEN STRESSED	

ACTIVITY LEVEL (check only one)

- ☐ Inactive – No regular physical activity with a sit-down job
- ☐ Light activity – No organized physical activity during leisure time
- ☐ Moderate activity – Occasionally involved on activities such as weekend golf, tennis, jogging, swimming or cycling
- ☐ Heavy activity – Consistent lifting, stair climbing, heavy construction, or regular participation in jogging, swimming, cycling or active sports at least 3 times per week.
- ☐ Vigorous activity – Participation in extensive physical exercise for at least 60 minutes per session 4 times per week

BEHAVIOR STYLE (check only one)

- ☐ You are always calm and easygoing
- ☐ You are usually calm and easygoing
- ☐ You are sometimes calm with frequent impatience
- ☐ You are seldom calm and persistently driving for advancement
- ☐ You are never calm and have overwhelming ambition
- ☐ You are hard driving and can never relax

This information will assist us in identifying your particular problem areas. Thank you for your time and patience in providing this information.