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?

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

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.

<table>
<thead>
<tr>
<th>DO YOU...</th>
<th>TYPICAL FOODS CONSUMED DURING EACH SPECIFIED TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>EAT BREAKFAST</td>
<td></td>
</tr>
<tr>
<td>EAT LUNCH</td>
<td></td>
</tr>
<tr>
<td>EAT DINNER</td>
<td></td>
</tr>
<tr>
<td>EAT BETWEEN MEALS</td>
<td></td>
</tr>
<tr>
<td>EAT AT NIGHT</td>
<td></td>
</tr>
<tr>
<td>EAT WHEN STRESSED</td>
<td></td>
</tr>
</tbody>
</table>

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.