Weight Management

Q U E S T I O N N A I R E

Today's date:

Patient name:

Date of birth:

	Height:	Current weight:	Childhood weight:	under	normal	over	
			How did you feel abou	t your weight as	a child?		
۲	How often do you weigh y	ourself?					
WEIGHT HISTORY	Highest adult weight: When:		Weights of significant others:				
			Spouse/partner	under	normal	over	
			Child 1	under	normal	over	
	Lowest adult weight:	When:	Child 2	under	normal	over	
8			Child 3	under	normal	over	
	What you did to get to your lowest weight:		Child 4	under	normal	over	
	, , ,	<u> </u>	Other	_ under	normal	over	

List	previous attempts to los	e weight:				
,	program:	How long you followed the diet/program	n: Results:			
Diet/	program:	How long you followed the diet/program	n: Results:			
Diet/ Diet/ List Media Media	program:	How long you followed the diet/program	n: Results:			
List weight loss medication (prescription and over-the-counter) you have taken:						
Hedio Solo	cation:	How long you took medication:	Weight loss and any side effects:			
Medio Medio	cation:	How long you took medication:	Weight loss and any side effects:			
List	List any supplements you take (vitamins, herbs, etc.):					

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Supplements:

What is the main thing motivating you to	ese weight now?	Do you eat for the following reasons?
At this time in your life, how important is and keep it off?	to lose weight	
12345Low importance </th <th>6 7 High importance pout food, weight,</th> <th></th>	6 7 High importance pout food, weight,	





Do you compensate for overeating by fasting, using laxatives, vomiting, or exercising?					no	yes
Do you ever hide your eating from others ?			no	someti	mes	often
Rate your current level of stress from 1 to 5 (1-not stressed, 5-very stressed):			1 2 Not stressed	3	4 Very st	5 tressed
What is the biggest cause of stress in your life righ	t now?	How many hours of s less than 6 hours	sleep do you g 6-7 hours	et each nig 7-9 hours		an 9 hours
What is the best thing you do to handle stress?		Do you feel rested o	n most days?		no	yes
Do you have a support system that will help you w losing weight? no	ith yes	Are you feeling dowr or hopeless?	n, depressed,		no	yes
Is there someone who might sabotage your efforts lose weight? no	to yes	Have you lost intere in doing things?	st or pleasure		no	yes
When would you be ready to start a weight loss promore than 6 months1-6 months30 days	-	urrently on a plan				
Do you count:	What do you e	eat/drink in a typical d	ay?			
CaloriesnoyesCarbohydratesnoyesFatnoyesOther	<u>Time</u>	Food/beverage		<u>A</u>	mount	
List any foods that you consider:						
Bad to eat Good to eat						
How do you feel about exercise? 1 2 3 4 5 Never liked it Have to for How often do you exercise? 1 2 3 4 5 Never done it Used to exercise, but	6 porce myself to do	7 8 Currently exerc	9	10 exercise regu 10 Currently exe ever	ercise	
How do you feel about exercise? 1 2 3 4 5 Never liked it Have to for How often do you exercise? 1 2 3 4 5	orce myself to do 6 ing: /week /week /week /week	7 8	Love to 9 riod of time in k before you fe al/health reason n exercising?	10 Currently exe ever your life we	ercise y day ere you m	ost