
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 or 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

Clothes don't fit anymore

More energy

Improve health

Better work opportunities

Feel better

More mobility

Want to wear smaller size

Look Better

Perform better

Live longer

Feel more confident socially

Reduce medications

Look more attractive to my partner

Upcoming vacation

Want to wear more stylish clothing

Attend an event

Other: _____

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

Skipping Meals

Eating Foods too high in fat

Craving carbohydrates

Eating too many meals in restaurants

Large portion sizes

Eating for reasons other than hunger

Too much alcohol

Eating before going to bed

Frequent snacking

Making yourself vomit after meals

Binging on food

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.