Weight Loss Intake Questionnaire

Why do you want to lose weight?

_____
_____

Describe the physical benefits you hope to achieve by losing weight:

_____
_____

Describe the medical benefits you hope to achieve by losing weight:

_____
_____

Describe the psychological benefits you hope to achieve by losing weight:

_____
_____

When did you become overweight?

___ Childhood ___Teens ___Adulthood ___Pregnancy ___Menopause

Did you ever gain more than 20 pounds in less than 3 months? Y N If so, how long ago? _____

As best as you can remember, how much did you weigh one year ago? _____

5 years ago? _____ 10 years ago? _____

What is your maximum (nonpregnant) lifetime weight? _____ Which year? _____

What is your desired weight? _____

Is your spouse/significant other overweight? Y N By how much? _____

Triggers for weight gain (check all that apply):

____ stress _____ marraige _____divorce _____illness _____travel _____ injury

____ nightshift work _____insomnia _____medication

____ quitting (circle all apply) smoking / alcohol / drugs

____ other _____

Previous weight loss programs (check all that apply):

_____ Weight Watchers _____ Nutrisystem _____ Jenny Craig _____ LA Weight Loss

_____ Atkins _____ South Beach _____ Zone diet _____ Medifast _____ Paleo diet

_____ HCG injections _____ Mediterranean diet _____ Ornish diet _____ other _____

What was your maximum weight loss? _____

What do you feel have been your most successful means of weight loss? _____

_____

What do you feel are your greatest challenges to weight loss? _____

_____

Have you ever taken medication to lose weight? (check all that apply)

_____ Phentermine ____ Meridia _____ Xenical/Alli _____ Phendimetrazine (Bontril)

_____ Topamax _____ Saxenda _____ Diethylpropion _____ Bupropion (Wellbutrin)

_____ Lorcaserin (Belviq) _____Qsymia _____ Contrave

Other _____

Which medications worked well? _____

Which medications had no effect? _____

Nutritional history

How often do you eat breakfast? _____ days a week at _____AM

How many times do you eat per day? _____ Meals _____ Snacks

Do you awaken hungry at night? Y N If so, how often? _____ times/week.

What do you do when you wake hungry? _____

Have you ever been diagnosed with an eating disorder? _____

Triggers for eating (check if apply): _____ stress _____ boredom _____ anger _____ sadness

_____ seeking reward _____ other - _____

Are there specific foods you crave? Y N What and when? _____

What type? (circle) sweet salty chocolate starches high fat large portions

How often do you eat fast food? _____ times/week, for breakfast / lunch / dinner (circle)

How often do you eat out or get take-out? _____ times/week

Restaurants most often chosen _____

Do you like vegetables? Y N Which do you eat regularly? _____

Do you eat meat? Y N Which do you eat regularly?_____

What is your typical breakfast? _____

Lunch? _____

Dinner? _____

Snack? _____

How many cups of water do you drink a day? _____ Sodas? _____ Diet or regular (circle)

How many caffeinated beverages a day? _____

Who plans meals in your home? _____ Shops? _____ Cooks?_____

Exercise

Do you enjoy exercise? _____ What type (s)? _____

What exercise do you do? _____

Duration _____ Number of times per week _____

What are your barriers to exercise? _____

Do you belong or have access to a gym? _____

Sleep

How many hours do you sleep per night? _____

Do you feel rested in the AM? _____

Do you take any sleep aids? Y N Which? _____

Do you snore/have you been told that you snore? Y N

Social

Smoking: _____ never _____ current smoker (____packs/day) _____ past smoker (quit _____ years)

Alcohol: _____ never _____ occasional _____ regularly (____ drinks per day/week)

Any history of alcohol abuse? _____

Drugs: _____never _____ current _____ past. Type: _____

Family

History of obesity/weight problems? _____ Which relatives?_____

_____

Any other thoughts or concerns you would like your physician to know about?

_____

_____

_____

_____