Wellness & Weight Loss Questionnaire

Today’s Date:_____________

Name ______________________________________________ Date of Birth: ___________________

Weight Loss Goals

What is your present weight? ____________
What is your ideal weight? ____________
When do you plan to meet your weight loss goal? (month/ year) __________

Weight Management History

What is your age? _____
What was your highest weight in the past 3 years? ________________
What was your lowest weight in the past 3 years? ________________

What weight loss programs have you tried? How long were you on the program? Have you had long term success (kept weight off longer than a year)? (select below)

<table>
<thead>
<tr>
<th>Program</th>
<th>How Long in Program?</th>
<th>Long term success? (Y/N)</th>
<th>Are you still on this program? (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight Watchers</td>
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<td>Jenny Craig</td>
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<td>NutriSystem</td>
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<td>E-Diets</td>
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<td>Other:</td>
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</table>

What diets have you tried in the past? How long were you on this diet? Have you had long term success? (select below)

<table>
<thead>
<tr>
<th>Diet</th>
<th>How Long on diet?</th>
<th>Long term success? (Y/N)</th>
<th>Are you still on this diet? (Y/N)</th>
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</thead>
<tbody>
<tr>
<td>Atkins Diet</td>
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<td>South Beach Diet</td>
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<td>Zone Diet</td>
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<td>Other:</td>
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</table>

Lifestyle & Activity

What type of work do you do? ____________________________
Do you have children? ______________
Do you smoke? ______________ If yes, how often? __________
Do you drink alcohol? ______________ If yes, how often? __________
Are there other individuals in your immediate family (parents, siblings) that are obese? ______________
(Lifestyle & Activity cont.)

How often do you exercise (check one)?

___ Rarely       ____ 1-2 days per week    ____ 3-5 days per week    ____ 6-7 days per week

How long is your exercise activity per session?   ____ None      ____ <30 min    ____ 30-60 min    ____ 1 hr    ___ >1 hr

What Type of Exercise do you do regularly? (select all that apply)

____ Walking       _____ Jogging/Running       ____ Weight Training       ____ Bicycling       _________ Other

How would you describe your general stress level?       ____ High Stress       _____ Moderate      _____ Low Stress

How many hours of sleep do you get per night?

____ <4 hours      _____ 4-5 hours    ____ 6-8 hours    ____ >8 hours

How do you feel mostly throughout the day?       ____ Tired & Fatigued      _____ Energetic & Alert

Dietary / Nutritional History

Select the statement that best describes you (check one)

○ TYPE I I can eat anything I want and not gain weight.

○ TYPE II I can lose or gain weight by adjusting my activity level and eating habits.

○ TYPE III I find it very hard to lose weight. I gain weight very easily and have to watch everything I eat.

Are you a vegetarian or vegan? _________

Approximately how many full meals do you eat a day? ________

How often do you snack between meals each day?  ____ none    ____ 1-2 times    ___ >3 times

Do you drink coffee regularly? _________ If yes, how many cups a day? _______

Do you drink soda regularly? _________ If yes, how many cans/cups a day? _______

How would you describe your typical eating habits: (check one)

___ I eat a very healthy and balanced diet, consisting mostly of fresh fruit and vegetables, lean meats and plenty of water. I rarely eat “junk food” or fast food.

___ I eat a moderately healthy diet, but on occasion eat unhealthy foods. I eat fast food more than 3 times a week. I drink sodas sometimes.

___ I eat a mostly poor and unhealthy diet. I eat junk food almost everyday and fast food more than 4 times a week. I drink sodas often instead of water.

Check all that apply:

☐ Do you often have cravings for sugary or other types of foods throughout the day?
☐ Are you currently struggling with weight loss?
☐ Do you lack protein in your diet from meats, legumes, and/or other sources?
☐ Do you struggle with eating healthy and regularly throughout the day?

How many times each day do you eat the following foods?

Starches (bread, bagel, roll, cereal, pasta, noodles, rice, potato)  ____ Never  ____ 1-2  ____ 3-5  ____ 6-8  ____ 9-11

Fruits  ____ Never  ____ 1-2  ____ 3-5  ____ 6-8  ____ 9-11

Vegetables  ____ Never  ____ 1-2  ____ 3-5  ____ 6-8  ____ 9-11

Dairy (milk, yogurt)  ____ Never  ____ 1-2  ____ 3-5  ____ 6-8  ____ 9-11

Meat, fish, poultry, eggs, cheese  ____ Never  ____ 1-2  ____ 3-5  ____ 6-8  ____ 9-11

Fats (butter, margarine, mayo, oil, salad dressing, sour cream, cream cheese)  ____ Never  ____ 1-2  ____ 3-5  ____ 6-8  ____ 9-11

Sweets (candy, cake, regular soda, juice)  ____ Never  ____ 1-2  ____ 3-5  ____ 6-8  ____ 9-11

What time of the day are you usually the most hungry?       ____ Morning       ____ Afternoon       ____ Evening       ____ Late Night

What meal of the day is the largest?       __________ Breakfast       __________ Lunch       _________ Dinner

Do you have food cravings often? If so, what type? _______ Sweets       _______ Salty       _______ Carbs