



Wellness & Weight Loss Questionnaire

If you are NOT interested in losing weight do not fill out this form.

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)

Program	How Long in Program?	Long term success? (Y/N)	Are you still on this program? (Y/N)
Weight Watchers			
Jenny Craig			
NutriSystem			
E-Diets			
Other: _____			

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

Diet	How Long on diet?	Long term success? (Y/N)	Are you still on this diet? (Y/N)
Atkins Diet			
South Beach Diet			
Zone Diet			
Other: _____			

Lifestyle & Activity

What type of work do you do? _____

Do you have children? _____

Do you smoke? _____ If yes, how often? _____ How many per day? _____

Do you drink alcohol? _____ If yes, how often? _____ Drinks/type per day? _____

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 ___ >1hr

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- 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