Weight Loss and Lifestyle Questionnaire

Name:_____ Date:_____

Weight & Height History:

1. Current height: ___ft. ___ in. What was your tallest height as an adult? ___ ft. ___ in.
2. Current weight: _____lbs. How long have you been this weight? _____
3. Heaviest weight (as an adult): ____lbs. Age ___ How long were you at this weight? _____
4. Lowest weight (not due to illness): _____lbs. Age____ How long did you maintain this weight? _____

What do you believe the reason for your weight gain is?

_____

_____

Weight Loss Goals:

What is your goal weight_____, which is a total of ___lbs.?

% of Current body weight. _____

What is your motivation to lose weight?

_____

Are you planning any major life changes (i.e. new job, moving, getting married) during the next 12 months?

☐ Yes ☐ No

If yes, please briefly describe, and give date (s) (month/year)

_____

Current Lifestyle/Eating Habits

Do you..	Typical foods consumed/Amounts
Eat breakfast	
Eat lunch	
Eat dinner	
Eat between meals	
Eat at night	
Eat when stressed	
How many oz of water	

How many meals per week do you typically eat from a fast food restaurant? _____

How many meals per week do you eat at a restaurant, coffee shop, cafeteria or similar establishment? _____

Please check the behaviors below that are a problem for you and which you believe contribute to weight.

- ☐ Overeating
- ☐ Snacking
- ☐ Cravings/ Describe

  _____
- ☐ Eating after I'm full
- ☐ Can't stop once I've begun
- ☐ Eating when anxious
- ☐ Eating when tired or bored
- ☐ Eating when stressed/ angry
- ☐ Eating when socializing
- ☐ Eating when alone

Please describe any other factors that contribute significantly to your gaining weight?

_____

_____

Did you usually have any of the following experiences during these occasions?

Eating much more rapidly than normal?	☐ Yes	☐ No
Eating until feeling uncomfortably full?	☐ Yes	☐ No
Eating large amounts of food when not feeling physically hungry?	☐ Yes	☐ No
Eating alone because of feeling embarrassed by how much you were eating?	☐ Yes	☐ No
Feeling disgusted with yourself, depressed, or feeling very guilty afterward?	☐ Yes	☐ No

Sleep Habits

How many hours of sleep do you get per night? ____ Do you feel rested? ____

Do you have trouble falling/ staying asleep? ___

Do you think you may have sleep apnea? (YES/NO) _____

If Yes, what are your symptoms? _____

What types of physical activity that you engaged in during the past six months?

_____

_____

What is your most frequent physical activity? _____

How many times per week do you exercise and for how long? _____

Diet History:

Please list any weight loss medications you have used and amount of weight loss/ Include if you gained back and how much.

1. **_____ 2. _____ 3. _____**

Please list any commercial weight loss programs you have used and amount of weight loss /Include if you gained back and how much.

1. **_____ 2. _____ 3. _____**

Please answer the following on a scale of 1-5.

Scale: LEAST 1 2 3 4 5 MOST

Are you ready for lifestyle changes to be part of your weight loss control? ____

How confident are you that you can lose weight this time? ____

How confident are you that you can keep the weight off this time? ____

Eating Disorder:

Have you ever had an eating disorder? ____

If yes, please describe. (Please include which disorder, and age(s))

_____

_____

Family History of Obesity

Does anyone in your family have a history of obesity? Please describe.

_____

_____

Does anyone in your family have a history of an eating disorder? Please describe.

_____

_____