WEIGHT LOSS QUESTIONAIRE

Name____

Birthdate________________________**Age**___________ **Sex: M F**

Today's Date____

Address____

____

Phones: Home____

Cell____

Work ____

Email____

How do you prefer to be contacted? Phone____Text ___ Email ____

Where do you work?____

How did you hear about *FOODFIT*? (circle all that apply)

Billboard Word of Mouth Newspaper Internet Client Referral

Name of Referring Client_______________________________________

Other____

Weight Loss History

1. What is your current weight?___________________________________

2. How much weight do you want to lose? ________________________

3. How long have you been trying to lose weight?_____________________

4. Have you lost weight before? Yes___ No___

   if Yes, how many times?____________________

5. What is the most weight you've ever lost? __________________lbs.

6. How long did you keep it off? ___________________

7. What happened to get you off track and regain the weight?____

   ____

8. Would you say you overeat due to:

   Emotion___________ Stress___________ Boredom_________

   Anxiety_____________ Uncontrollable Cravings____________

9. Other (please explain)____

   ____

10. 7. What are or have been your main obstacles to successfully maintaining your ideal weight?____

   ____

11. What was the highest weight you've ever been?______________________

12. When were you at your highest weight? (date) ______________________

13. What is your goal weight? _________________________

14. What are some of your favorite foods?____________________________

   ____

15. Are there certain foods that you do not eat? _______________________

   ____

16. Do you have any food allergies? if yes please list. ____________________

____

17. Do you drink alcohol? if yes how much and how often __________________

____

18. To tailor your weight loss experience to your needs it would be useful to know your expectations. Please indicate which of the following feels right to you.

_____ I want a lot of structure, please tell me exactly what to eat at every meal.

_____ I want some structure but freedom to select certain foods.

_____ I want to make it up as I go using the guidelines set forth in the *FOODFIT* program.

Exercise History

19. Do you currently engage regular exercise (at least twice a week) in any of the forms listed below?

20. _____ Cardiovascular exercise (ie, walking, jogging, cycling, swimming, elliptical training, spinning, step or other group exercise classes? If so, which?

____

____

21. _____ Strength training exercise, ie, weight lifting, calisthenics, Pilates? If so which?

____

____

22. ____ Flexibility exercise, ie, Yoga, Pilates, stretching. If so which?

____

____

23. ____ Other exercise.____

____

24. ______ I currently do not engage in regular exercise, but used to in the past.

25. _______ I've never engaged in regular exercise.

Health/Medical History

26. Have you or anyone in your immediate family had: Please put "S" for Self/ "F" for family member.

___ Cancer

___ Diabetes Type I Type II

___ Heart Disease

___ High Cholesterol

___ High Blood Pressure

___ Osteoporosis

___ Thyroid Disorder

27. Do you have complaints about any of the following:

___ Appetite

___ Bleeding gums

___ Bruising

___ Constipation

___ Diarrhea

___ Edema

___ Menstrual Difficulties

___ Vision in dim light

___ Sudden weight change

___ Difficulty chewing or swallowing

___ Frequent Indigestion

___ Joint pain or injuries

___ Back pain or injuries

___ Muscle Pain or injuries

______Other (please explain)

____

____

28. Do you smoke or use tobacco in any way? Yes No.
If yes how much/day________________

29. Are you, or do you plan to become pregnant in the next 6 months? Yes No

30. Are you taking any medications? Yes No
If yes, please list each and their purpose:

____

____

31. How would you rate your average consistent stress level on a scale of 1 - 10.
1= almost no stress at all 10 = extremely stressed all day

1 2 3 4 5 6 7 8 9 10

Supplements and Current Nutritional Practices

31. Please list any and all supplements you are currently taking including dosages.

____
____
____
____
____
____
____
____
____
____

32. Are you taking any protein powders, bars or energy product? If yes please list.

____
____
____
____

33. Please use the space below to give an example of a "typical day" of foods that you eat. Please include all snacks and beverages as well, use extra space on the back if needed.

Breakfast: Time____

____
____
____

Lunch: Time_____

____
____
____

Dinner: Time_____

____
____
____
____

Snacks listed with times eaten.____

____

____

Readiness

34. How long have you struggled with the weight issue? ________________

35. How long have you been thinking about losing weight? _______________

36. What new habits, conditions, beliefs or attitudes are you willing to embrace, to reach your goal?

____

____

37. What old habits, conditions, beliefs, or attitudes are you willing to give up to reach your goal? ____

____

38. How ready to embark this lifestyle change do you feel?

___Not ready at all **___Some what ready but scared**

___Ready **___Nothing will stand in my way!**

39. How supportive is/are your immediate family?

___ Not supportive, they sabotage my efforts

___ Somewhat supportive but I'm still on my own

___ They don't have a strong feeling about my weight loss either way

___ Supportive, they want me to be happy

___ My Family is/are my biggest supporters and strength!

40. Is there anything else we should know about you to help tailor your program?

____

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____