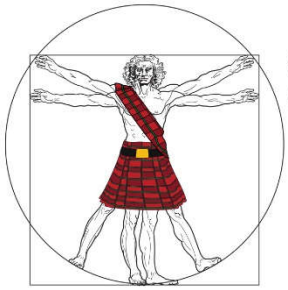

Scott Medical SOLUTIONS

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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 on meeting 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? _____ How often? _____
Do you drink alcohol? _____ How often? _____
Are there any 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?

Walking ☐ Jogging/Running ☐ Weight Training ☐ Bicycling ☐ Other: _____

How would you describe your general stress level? High Stress ☐ Moderate Stress ☐ 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 ☐ Not Tired But Not Energetic ☐ 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 must watch everything I eat.

Are you 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? Yes ☐ No ☐ How many cups a day? _____

Do you drink soda regularly? Yes ☐ No ☐ How many cans/cups a day? _____

How would you describe your 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 every day 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 (breads, cereals, pastas, noodles, rice, potatoes): 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, cheese): Never ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ 9-11 ☐

Meat (fish, pork, poultry, beef, etc.): Never ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ 9-11 ☐

Fats (butter, margarine, mayo, oil, salad dressing): Never ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ 9-11 ☐

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

What time of day are you usually the hungriest? 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 ☐