

MY PERSONAL WEIGHT JOURNEY

Take a moment to answer the following questions about your weight, motivations, and challenges to help guide conversations with your health care professional about a weight-management plan that fits your lifestyle.

PERSONAL INFORMATION

Weight: _____ (lbs)

Height: _____ (ft/in)

What do you feel your weight may be holding you back from doing?

? Approximately how much weight would you like to lose to help you reach your goals? _____ (lbs)

WEIGHT-RELATED CONDITIONS

Select which of the following conditions or diseases you have. **Write in** any prescription or over-the-counter products you are currently taking.

Condition or Disease (select)*	Prescription or Over-the-Counter Products (write in)
<input type="checkbox"/> Sleep disorders (eg, sleep apnea, insomnia)	
<input type="checkbox"/> Chronic pain conditions (eg, arthritis)	
<input type="checkbox"/> Cardiovascular disease	
<input type="checkbox"/> Respiratory disease	
<input type="checkbox"/> Gastrointestinal disorders (eg, liver problems)	
<input type="checkbox"/> Endocrine disorders (eg, hormone)	
<input type="checkbox"/> Diabetes or prediabetes	
<input type="checkbox"/> Depression	
<input type="checkbox"/> Other:	

*This is not a complete list of all possible weight-related conditions.

LIFE MILESTONES/EVENTS & WEIGHT

In the space provided, share any life events that relate to your weight loss or weight gain. Add any specifics you would like. Possible life events may include: Special occasions/events (eg, wedding, baby, class reunion, vacation), Home or work changes (eg, job change, divorce, personal loss, move), Health or medical changes (eg, nutritionist, injury, surgery, medication)

When did this occur? (age)	Event	How much weight did you lose/gain?	Weight Loss	
			What did you do to lose weight?	Would you do it again? (Y/N)
_____ years old		Lost _____ (lbs) / Gained _____ (lbs)		
_____ years old		Lost _____ (lbs) / Gained _____ (lbs)		
_____ years old		Lost _____ (lbs) / Gained _____ (lbs)		

WEIGHT-LOSS/MANAGEMENT EFFORTS

How would you describe your efforts to lose or maintain weight? Please select all that apply.

Current efforts	Tried it in the past	Doing it now
Physical activity	<input type="checkbox"/>	<input type="checkbox"/>
Healthy eating	<input type="checkbox"/>	<input type="checkbox"/>
Over-the-counter products	<input type="checkbox"/>	<input type="checkbox"/>
Prescription medication	<input type="checkbox"/>	<input type="checkbox"/>
Commercial weight-loss programs (eg, Weight Watchers®)	<input type="checkbox"/>	<input type="checkbox"/>
Bariatric surgery	<input type="checkbox"/>	<input type="checkbox"/>

How long have you been trying to lose weight?

Less than 2 years

2-4 years

5-9 years

As long as I can remember

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CURRENT EATING & ACTIVITY ROUTINES

How would you describe your eating habits? Please select all that apply.

☐ Eat 3 meals a day

☐ Frequent snacker

☐ Binge eater

☐ Constant dieter

☐ Eat more than 3 meals
a day

☐ Healthy eater

☐ Emotional eater

☐ Other _____

What approaches to healthy eating have you tried in the past? **Circle** what worked for you and **mark an X over** what didn't work.

Limiting my portion size
(eg, using a smaller plate)

Using meal replacements

Tracking activity and calories

Cooking meals at home

Avoiding sugary foods
and drinks

Reading food labels

Other _____

Approximately, how many minutes total per week do you spend doing physical activities such as going for a walk, cleaning the house, climbing stairs, light yard work, or biking?

60 min or less (1 hour)

60-120 min (1-2 hours)

120-180 min (2-3 hours)

more than 180 min (3 hours)

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Any other weight-related information your health care professional should know?
