LW4L
LOSE WEIGHT FOR LIFE

WEIGHT LOSS QUESTIONNAIRE

DATE *(mm/dd/yy)*

NAME

DATE OF BIRTH *(mm/dd/yy)* **AGE**

ADDRESS

CITY

STATE, ZIP EMAIL

CONTACT NUMBER

((xxx) xxx-xxxx)

SEX ◯ Male ◯ Female

MARITAL STATUS

◯ Married
◯ Single
◯ Divorced
◯ Widowed
◯ Other

HEIGHT *(inches)* **CURRENT WEIGHT** *(lbs)* **DESIRED WEIGHT** *(lbs)*

1 **What is your primary reason for wanting to lose weight?**

2 **At this time in your life, how important is it to lose weight and keep it off?**

(Low importance) ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 *(High importance)*

3 **How much time do you spend thinking about food, weight, body, calories, and fat?**

4 **Check all medical issues that pertain to you:**

☐ Heart Disease ☐ Asthma ☐ Gout ☐ Anemia ☐ High Blood Pressure
☐ Thyroid Disorder ☐ Osteoporosis ☐ Mood Disorders ☐ High Cholesterol ☐ Diabetes
☐ Arthritis ☐ Cancer ☐ Sleep Apnea ☐ GI Disorder ☐ Urinary Incontinence

Other

5 **Are you currently on a diet for medical reason?** ◯ No ◯ Yes **If yes, check all that may apply:**

☐ Diabetic ☐ Low Fat ☐ Low Carb ☐ Low Calorie ☐ Kosher
☐ Vegan ☐ Low Sodium ☐ Vegetarian

6 **Have you ever been diagnosed with an eating order?** ◯ No ◯ Yes **If yes, please explain:**

7 **Are you receiving any psychiatric/psychological services at this time?**

8 **Please list allergies to medications and your reactions:**

9 **List all your current medications including vitamins, aspirin, and/or supplements:**

Drug Name	Dose	How Often

10 **List any past medical surgeries and year:**

11 **Use of Alcohol:**

- ◯ Daily consumption
- ◯ 0
- ◯ 1-2 drinks
- ◯ 3-5 drinks
- ◯ >5 drinks

12 **Use of Tobacco:**

- ◯ Never
- ◯ Previously/Quit

Number of packs: _____

13 **Do you have sleep apnea?**

- ◯ No
- ◯ Yes

14 **What do you think is your largest roadblock to losing weight?** *(check all that may apply)*

Diet:

- ☐ Portion control
- ☐ Bored snacking
- ☐ Emotional or stress snacking
- ☐ Not feeling full after a healthy portion
- ☐ Not eating the right foods: due to personal food preferences or due to the lack of time to find right foods

Exercise:

- ☐ Not enough time to exercise
- ☐ Not enough energy to exercise
- ☐ No available exercise equipment

15 **How supportive is your family and friends with your weight loss goals?**

- ◯ Very supportive and encouraging
- ◯ Moderately supportive
- ◯ Indifferent
- ◯ Not supportive or encouraging

16 **How confident and optimistic are you in your ability to lose weight through this medical supervised weight management program?**

- ◯ I am sure I'm going to reach my goal weight
- ◯ I think I will come close to reaching my goal weight
- ◯ I don't think I will lose weight

17 **Do you exercise regularly now?** ◯ No ◯ Yes

If yes, what activity?

How many times per week? _____ **For how long?** _____

18 **Are you planning on exercising regularly during your weight loss program?** ◯ No ◯ Yes

19 **How many times each day do you eat the following types of foods?** *(please select one choice under each food type)*

STARCH Bread, cereal, pasta, rice, potato	**FRUIT**	**VEGETABLE**	**DAIRY** Milk, yogurt, cheese, ice cream	**MEAT/ POULTRY**	**FISH**	**FAT** Butter, mayo, oil, cream cheese	**SWEETS**
◯ Never	◯ Never	◯ Never	◯ Never	◯ Never	◯ Never	◯ Never	◯ Never
◯ Less than 1	◯ Less than 1	◯ Less than 1	◯ Less than 1	◯ Less than 1	◯ Less than 1	◯ Less than 1	◯ Less than 1
◯ 1-2	◯ 1-2	◯ 1-2	◯ 1-2	◯ 1-2	◯ 1-2	◯ 1-2	◯ 1-2
◯ 3-5	◯ 3-5	◯ 3-5	◯ 3-5	◯ 3-5	◯ 3-5	◯ 3-5	◯ 3-5
◯ 6-8	◯ 6-8	◯ 6-8	◯ 6-8	◯ 6-8	◯ 6-8	◯ 6-8	◯ 6-8
◯ 9+	◯ 9+	◯ 9+	◯ 9+	◯ 9+	◯ 9+	◯ 9+	◯ 9+

20 **Do you eat for the following reasons?**

Self reward:	◯ No	◯ Sometimes	◯ Often
Stressed:	◯ No	◯ Sometimes	◯ Often
Angry:	◯ No	◯ Sometimes	◯ Often
Depressed:	◯ No	◯ Sometimes	◯ Often
Nervous/worried:	◯ No	◯ Sometimes	◯ Often
Lonely:	◯ No	◯ Sometimes	◯ Often
Other: _____	◯ No	◯ Sometimes	◯ Often

21 **Do you binge eat (large amounts of food in a short period of time)?** ◯ No ◯ Sometimes ◯ Often

22 **Rate your level of stress:**

(Not stressed) ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 *(Very stressed)*

23 **What is the biggest cause of stress in your life right now?**

24 **Which meals do you regularly eat?** *(please check all that may apply)*

☐ Breakfast ☐ Lunch ☐ Brunch ☐ Dinner ☐ Snacks

25 **When do you usually snack?** *(please check all that may apply)*

☐ Morning ☐ Afternoon ☐ Evening ☐ Late night ☐ Throughout the day

26 **What are your favorite snack foods?**

27 **Do you eat out or order food in?** ◯ No ◯ Yes **If yes, how often?**

28 **How is your food usually prepared?**

◯ Baked ◯ Broiled ◯ Fried ◯ Steamed ◯ Poached ◯ Microwave ◯ Barbecue

◯ Other _____

29 **What beverages do you drink daily and how much?**

☐ Water					times or cups per day (8 oz)
☐ Juice	☐ Natural	☐ Fruit drinks			times or cups per day
☐ Coffee	☐ Regular	☐ Decaf			times or cups per day
☐ Tea	☐ Regular	☐ Decaf			times or cups per day
☐ Soda	☐ Regular	☐ Diet			times or cups per day (12 oz)
☐ Milk	☐ Whole	☐ 2%	☐ Skim		times or cups per day
☐ Alcohol	☐ Beer	☐ Wine	☐ Liquor		times or cups per day
☐ Other					times or cups per day

30 **What is the hardest part about managing your weight?**

31 **Do you consume more than half of your daily calories after 7 pm?** ◯ No ◯ Yes

32 **Does it take you longer than 10 minutes to eat a meal?** ◯ No ◯ Yes

33 **Does anyone else in your family struggle with weight gain and difficulty losing weight also?** ◯ No ◯ Yes

If yes, please list their relation to you and if they are overweight as a result of this struggle?

34 **Please indicate the following methods of weight loss you have attempted and comment on your experience. Indicate pounds lost and length on program:**

Commercial Diets	Comments	Pounds Lost	Length of Participation
☐ Weight Watchers			
☐ Jenny Craig			
☐ Overeaters Anon			
☐ TOPS			
☐ Nutrisystem			

Prescription Diets	Comments	Pounds Lost	Length of Participation
☐ Adupex-P			
☐ Bontril			
☐ Desoxyn			
☐ Lonamin			
☐ Meridia			
☐ Xenical/Alli			

Liquid Diets	Comments	Pounds Lost	Length of Participation
☐ Optifast			
☐ HMR			
☐ Medifast			

Popular Diets	Comments	Pounds Lost	Length of Participation
☐ Atkins			
☐ Pritikin			
☐ South Beach			
☐ The Zone			
☐ Self Initiated			

35 **Have you had any type of weight loss surgery in the past?** ◯ No ◯ Yes

If yes, please explain when you had surgery and what type of surgery you had:

36 **Do you have any questions or concerns that you specifically want to address?**

DIET READINESS SELF ASSESMENT

For each question, circle the answer that best describes how you feel. There is no right or wrong answers. Be as honest as you can be with yourself.

SECTION 1: Goals and Attitudes

1 Compared to other attempts, are you motivated to lose weight this time? *(check one)*

- ◯ Not motivated
- ◯ Slightly motivated
- ◯ Somewhat motivated
- ◯ Very motivated
- ◯ Highly motivated

2 How certain are you that you will be committed to a weight loss program for the time it will take to reach your goal?

- ◯ Not at all certain
- ◯ Slightly certain
- ◯ Somewhat certain
- ◯ Very certain
- ◯ Extremely certain

3 Consider all outside factors at this time in your life. Will you be able to make the effort required to stick to a diet? *(check one)*

- ◯ Cannot make the effort to handle outside factors
- ◯ Can handle some of the outside factors
- ◯ Can probably handle most of the outside factors
- ◯ Can handle all of the outside factors
- ◯ Can do whatever I need to do to handle the outside factors

4 Think honestly about how much weight you hope to lose and how quickly you hope to lose it. Figuring a weight loss of 1 to 2 pounds per week, how realistic is your expectation? *(check one)*

- ◯ Very unrealistic
- ◯ Somewhat unrealistic
- ◯ Moderately unrealistic
- ◯ Somewhat realistic
- ◯ Very realistic

5 While dieting, do you think about eating a lot of your favorite foods? *(check one)*

- ◯ Always
- ◯ Frequently
- ◯ Occasionally
- ◯ Rarely
- ◯ Never

6 While dieting, do you feel deprived, angry and/or upset? *(check one)*

- ◯ Always
- ◯ Frequently
- ◯ Occasionally
- ◯ Rarely
- ◯ Never

SECTION 2: Hunger and Eating Cues

7 When food comes up in conversation or in something you read, do you want to eat even if you are not hungry? *(check one)*

- ◯ Never
- ◯ Rarely
- ◯ Occasionally
- ◯ Frequently
- ◯ Always

8 How often do you eat because of physical hunger? *(check one)*

- ◯ Always
- ◯ Frequently
- ◯ Occasionally
- ◯ Rarely
- ◯ Never

9 If your favorite foods are around the house, do you have trouble controlling urges? *(check one)*

- ◯ Never
- ◯ Rarely
- ◯ Occasionally
- ◯ Frequently
- ◯ Always

SECTION 3: Controlling Eating

If the following situations occurred while you were on a diet, would you be likely to eat more or less immediately afterward and for the rest of the day?

10 Although you planned on skipping lunch, a friend talks you into going out for a midday meal. *(check one)*

- ◯ Would eat much less
- ◯ Would eat somewhat less
- ◯ Would make no difference
- ◯ Would eat somewhat more
- ◯ Would eat much more

11 You "break" your diet by eating a fattening, "forbidden" food. *(check one)*

- ◯ Would eat much less
- ◯ Would eat somewhat less
- ◯ Would make no difference
- ◯ Would eat somewhat more
- ◯ Would eat much more

12 You have been following your diet faithfully and decide to test yourself by eating something you consider a treat. *(check one)*

- ◯ Would eat much less
- ◯ Would eat somewhat less
- ◯ Would make no difference
- ◯ Would eat somewhat more
- ◯ Would eat much more

SECTION 4: Binge Eating and Purging

13 Aside from holidays, have you ever eaten a large amount of food rapidly and felt that your eating was out of control? *(check one)*

- ◯ Yes
- ◯ No

14 If you answered yes to #13 above, how often have you engaged in this behavior during the last year? *(check one)*

- ◯ Less than once a month
- ◯ About once a month
- ◯ A few times a month
- ◯ About once a week
- ◯ About three times a week
- ◯ Daily

15 Have you ever purged (used laxatives, diuretics or induced vomiting) to control your weight? *(check one)*

- ◯ Yes
- ◯ No

16 If you answered yes to #15 above, how often have you engaged in this behavior during the last year? *(check one)*

- ◯ Less than once a month
- ◯ About once a month
- ◯ A few times a month
- ◯ About once a week
- ◯ About three times a week
- ◯ Daily

SECTION 5: Emotional Eating

17 Do you eat more than you would like to when you have negative feelings such as anxiety, depression, anger or loneliness? *(check one)*

- ◯ Never
- ◯ Rarely
- ◯ Occasionally
- ◯ Frequently
- ◯ Always

18 Do you have trouble controlling your eating when you have positive feelings? Do you celebrate feeling good by eating? *(check one)*

- ◯ Never
- ◯ Rarely
- ◯ Occasionally
- ◯ Frequently
- ◯ Always

19 When you have interpersonal stress, or after a difficult day at work, do you eat more than you'd like? *(check one)*

- ◯ Never
- ◯ Rarely
- ◯ Occasionally
- ◯ Frequently
- ◯ Always

SECTION 6: Exercise Patterns and Attitudes

20 How often do you exercise? *(check one)*

- ◯ Never
- ◯ Rarely
- ◯ Occasionally
- ◯ Somewhat
- ◯ Frequently

21 Within your physical limitations, do you believe that you can exercise regularly? *(check one)*

- ◯ Not at all
- ◯ Slightly
- ◯ Somewhat
- ◯ Highly
- ◯ Completely Confident

22 When you think about exercise, do you develop a positive or negative picture in your mind? *(check one)*

- ◯ Very negative
- ◯ Somewhat negative
- ◯ Neutral
- ◯ Somewhat positive
- ◯ Completely positive

23 How certain are you that you can work regular exercise into your daily schedule? *(check one)*

- ◯ Not at all certain
- ◯ Slightly certain
- ◯ Somewhat certain
- ◯ Very certain
- ◯ Extremely certain

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PATIENT HEALTH QUESTIONNAIRE (PHQ9)

NAME _____ **DATE** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(check one for each)*

		Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	◯	◯	◯	◯
2	Feeling down, depressed, or hopeless	◯	◯	◯	◯
3	Trouble falling or staying asleep, or sleeping too much	◯	◯	◯	◯
4	Feeling tired or having little energy	◯	◯	◯	◯
5	Poor appetite or overeating	◯	◯	◯	◯
6	Feeling bad about yourself or that you are a failure or have let yourself or your family down	◯	◯	◯	◯
7	Trouble concentrating on things, such as reading the newspaper or watching television	◯	◯	◯	◯
8	Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	◯	◯	◯	◯
9	Thoughts that you would be better off dead, or of hurting yourself	◯	◯	◯	◯
	Total				

10 **If you checked off any problems, how difficult have these problems made it for your to do your work, take care of things at home, or get along with other people?**

- ◯ Not difficult at all
- ◯ Somewhat difficult
- ◯ Very difficult
- ◯ Extremely difficult

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PATIENT HEALTH QUESTIONNAIRE (PHQ9)

NAME _____ **DATE** _____

Please complete this questionnaire, which will help you and your physician understand your physical activity patterns.

1 **What types of physical activities do you enjoy?**

2 **How often do you participate in these activities?**

- ◯ Rarely
- ◯ Less than once a month
- ◯ 1-3 a month
- ◯ once a week
- ◯ Daily

3 **What exercises do you do regularly?**

4 **How often, and for how long each time, do you do these activities?**

5 **What gets in the way of you consistently engaging in physical activity/exercise?**

6 **How many hours of television do you watch every day?**

7 **How many hours are you at a computer/desk every day?**

8 **What types of exercise equipment or exercise tapes do you have at home?**

9 **Do you belong to a health club or attend classes?** ◯ No ◯ Yes

10 **How often do you attend?**

11 **Would you like to change your physical activity/exercise habits?** ◯ No ◯ Yes

12 **Which habits would you like to begin to change?**

BENEFITS OF PHYSICAL ACTIVITY

Post this list in a place where you will see it often, such as a bathroom mirror, bulletin board, or refrigerator door.

There are many possible benefits to becoming more physically active. Read through this list and check the benefits that are important to you.

POTENTIAL BENEFITS

- ☐ Increase stamina
- ☐ Stimulate weight loss
- ☐ Lower blood cholesterol
- ☐ Lower blood pressure
- ☐ Improve self-image
- ☐ Improve mood
- ☐ Enhance quality of life
- ☐ Sleep better
- ☐ Strengthen heart and lungs
- ☐ Decrease stress
- ☐ Increase energy
- ☐ Maintain appropriate weight
- ☐ Lower triglycerides
- ☐ Control blood sugar levels/diabetes
- ☐ Feel better
- ☐ Reduce feelings of depression and anxiety
- ☐ Improve productivity
- ☐ Build and maintain healthy bones, muscles, and joints
- ☐ Increase muscle tone
- ☐ Reduce risk of dying prematurely

What other ways do you think you could benefit from being physically active?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____