Weight and Health Questionnaire

Name: ____ Date: __________________

Background Information

Age: _______ Birth Date: _____________ Preferred Phone Number: _____________________

Email: _________________________ Marital Status: ___________ Gender: Male Female

Occupation: ______________________________ Work Hours: ____________________________

Highest Level of Education: ____

Primary Language (circle): English Spanish Other, please list: _______________________

Smoking status: ______ Never _______ Former ______Current

General Health Information

List any health problems and physical limitations: _____________________________________

____

____

List any allergies/intolerances: ____

List All Medications, Vitamins, and Herbals:	Dosage:

How many hours of sleep do you average per night? _____ Is your sleep restful? Yes No

How do you rate the stress in your life, 10 being the highest? 1 2 3 4 5 6 7 8 9 10

How do you cope with stress? ____

List any cultural or religious practices related to your health or diet: _________________________

____

How do you rate your readiness to make lifestyle changes, 5 being most ready? 1 2 3 4 5

How do you rate your confidence to make lifestyle changes, 5 being most confident? 1 2 3 4 5

Weight Information:

Current Weight: _______ Height: _________

What was your lowest and highest adult weight? __________lb __________lb

Describe any weight changes (gain or loss) in the past 2 years: ____________________________

____

Have you dieted in the past for weight loss? No Yes If yes, please indicate what you

have done: ____

What makes it hard for you to lose weight and keep it off? _________________________________

____

What has helped you lose weight? ____

How much weight would you like to lose? ____

How will you benefit from this weight loss? ____

Physical Activity Information:

What is the most physically active thing you do in a day? _________________________________

What, if any, regular exercises do you do? ____

How many days a week? ____________ How many minutes per day? _____________________

At what level of intensity (light, moderate, or high)? _____________________________________

What time(s) of day can you fit exercise into your schedule? ______________________________

List any physical limitations to exercising: ____

Nutrition Information:

In the chart below, fill in your typical day's food/meal intake:

Meal	*Time*	*Where Eaten*	*Foods and Beverages Eaten*
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			

How often do you eat out at restaurants/fast food? ______________________________________

Which grocery stores do your foods come from? ____

Who does the grocery shopping? ____

Who plans the meals at home? ____

Who prepares the meals at home? ____

What 1 or 2 things would you like to change with your diet? _______________________________

____

Client Signature: ________________________________ Date: __________________

Clinician Signature: ________________________________ Date: ________________

Clinician Only:

BMI:
WC: