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WEIGHT MANAGEMENT INTAKE FORM

Whether it's your personal medical history, or writing down specific, attainable short- and log-term goals, this form can help you and your health care team plan for your weight management.

Name _____ Date of Visit _____

Date of Birth _____ Height _____ Weight _____ BMI _____

Please answer these questions as truthfully as possible so together we can develop a personalized weight-loss planner you.

Do you ever feel like your eating patterns can get out of control? YES____ NO____

Do you eat between meals? YES____ NO____

Do you eat as a response of your emotions? YES____ NO____

Do you have any dietary restriction? YES____ NO____

Do you currently take part in physical activity? YES____ NO____

Have you been diagnosed with one of the following?

Type 2 Diabetes? YES____ NO____

High Blood pressure? YES____ NO____

High Cholesterol? Yes____ NO____

What prescription medication, if any, do you currently take?_____

How many times a week do you take part in physical activity? _____ How long do your sessions last?_____

What type of physical activity?_____

What are your weight/obesity-management goals?

Short-term goals:_____

Long-term goals:_____

How many serious weight-loss attempts have you made in the past 5 years?_____

Did you participate in any structured weight-loss programs in the past and, if so, which ones?_____

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Was there a program that seemed to work best for you?_____

____

What are some Barries that have kept you from losing weight and maintaining weight loss in the past? (Eg, nutritional choices, no time for exercise, health issues)

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