WEIGHT LOSS/FOOD HISTORY

_____ _____ _____lbs _____ft_____in
Name Age Weight Height

MEDICAL HISTORY

Have you been given any dietary restrictions? **NO** ☐ **YES** _____

_____

Do you have any restrictions/limitations on exercise? **NO** ☐ **YES** _____

_____

Do you have any medical problems? **NO** ☐ **YES** _____

_____

Do you regularly take any medications? **NO** ☐ **YES** _____

_____

MENTAL HEALTH HISTORY

Have you ever sought professional help for emotional/mental problems? **NO** ☐ **YES** ☐

Problem	Age	Duration (wks)	Type of Professional Help

Check all that apply to you, indicating if it is in the past and/or currently:

Often felt hopeless about the future	☐ Past ☐ Present
Little interest or pleasure in doing things	☐ Past ☐ Present
Thought of harming or killing myself	☐ Past ☐ Present
Made attempts to harm or kill myself	☐ Past ☐ Present
Been subjected to physical abuse	☐ Past ☐ Present
Been subjected to emotional abuse	☐ Past ☐ Present
Been subjected to sexual abuse	☐ Past ☐ Present
Have immediate family members that are alcoholics	☐ Past ☐ Present

_____

NAME

FAMILY HISTORY

Please indicate average height and weight of spouse/family of origin as adults (or current age if younger than adult). If you do not know height and weight, please indicate if they are average, below average, or above average weight.

	Height (ft/in)	Weight (ft/in)	Current Age (or year of death)
Spouse/Significant Other			
Father			
Mother			
Oldest Sibling-Male□ Female□			
Next Sibling- Male □ Female □			
Next Sibling- Male □ Female □			
Next Sibling- Male □ Female □			
Next Sibling- Male □ Female □			

Was food available as needed in your home growing up? **YES** □ **NO** _____
_____

Were you allowed relatively free access to foods when you felt you were hungry? **YES** □ **NO** _____
_____

Who was responsible for cooking in your home? _____

Was food used as punishment or reward? **NO** □ **YES** _____
_____

Did food/meal times hold any specific significance for you (e.g., did family fights occur at table)? **NO** □ **YES**
_____
_____
_____

Do you have any food-specific memories that hold strong emotion for you? **NO** □ **YES** _____
_____
_____
_____

_____
NAME

WEIGHT HISTORY

1. At what age were you first overweight by 10 lbs or more? _____ How do you remember? (e.g. pictures, clothes sizes, etc.) _____
2. What has been your highest weight as an adult? _____ at age _____
3. What has been your lowest weight as an adult? _____ at age _____
   If this was achieved after a weight loss effort, please explain: _____
4. Please list other weight loss efforts you have made (e.g., Weight Watchers, Phen-Fen, etc.)

Age	Method used to lose weight	# of lbs lost	How long did you keep it off

PREGNANCY (FOR WOMEN ONLY)

Please indicate for each pregnancy:

1. Start of pregnancy – age _____ weight _____
   At delivery – age _____ weight _____ ☐ not applicable
   Lowest weight after delivery - _____
2. Start of pregnancy – age _____ weight _____
   At delivery – age _____ weight _____ ☐ not applicable
   Lowest weight after delivery - _____
3. Start of pregnancy – age _____ weight _____
   At delivery – age _____ weight _____ ☐ not applicable
   Lowest weight after delivery - _____
4. Start of pregnancy – age _____ weight _____
   At delivery – age _____ weight _____ ☐ not applicable
   Lowest weight after delivery - _____

Do you have regular menstrual cycles? **NO** ☐ **YES** ☐

If yes, does your cycle seem to affect your eating pattern? **NO** ☐ **YES** _____

_____

NAME

FACTORS IN OVEREATING

Problem Foods: _____

_____

Specific trigger events (e.g., work meeting): _____

_____

_____

Healthy foods that you enjoy: _____

_____

Specific goals: _____

_____

Personal Plan (e.g., daily exercise, cut out certain foods, etc.): _____

_____

Low Motivation Times (e.g., evening): _____

_____

Recent example of overeating: _____

_____

Recent example of making good food choices: _____

_____

Healthy foods that seem to satisfy urges the most: _____

_____

Recent example of making good fitness choices: _____

_____

_____
NAME

PROBLEM EATING

1. At any point in the past have you binged (eaten an unusually large amount of food within a 2 hour period) **NO**
   ☐ > 1 day/week ☐; 1 day/week ☐; 2-3 day/ week ☐; 4-5 days/week ☐; 6-7 days/week ☐

2. Did you feel you couldn't stop eating or control what/how much you were eating? **NO** ☐ **YES** ☐ **N/A**☐

3. Approximately how long does the episode of eating last, from the time you started eating until the time you stopped and did not eat again for at least 2 hours? _____.

4. Was there a specific time/place this typically occurred? **NO** ☐ **YES** _____

5. **Check all that typically applied during these binges:**
   ☐eating much more rapidly than normal ☐feeling disgusted, depressed, and/or guilty because I overate
   ☐eating until I was uncomfortably full ☐eating large amounts even when I wasn't physically hungry
   ☐eating alone because I was embarrassed by how much I was eating

6. What were typical foods/amounts eaten at those times (e.g., bag of chips, 2 cups ice cream, etc.)
   _____
   _____

7. In general how upset were you by overeating episodes described above?
   ☐ Not at all ☐ Slightly ☐ Moderately ☐ Greatly ☐ Extremely

8. During the past 3 months how many times did you exercise for more than 1 hour at a time after eating, specifically in order to avoid gaining weight?
   ☐ N/A ☐< 1 time/wk ☐1 time/wk ☐2 - 3 times/wk ☐4 - 5 times/wk ☐>5 times/wk

_____

NAME

GENERAL EATING HABITS

How many meals do you eat ***weekly*** from a fast food restaurant or convenience stores?

_____ Breakfast _____ Lunch _____ Dinner

How many meals ***weekly*** do you eat at a traditional restaurant, coffee shop, cafeteria, a similar establishment?

_____ Breakfast _____ Lunch _____ Dinner

How many meals ***weekly*** do you eat out with others (including family)?

_____ Breakfast _____ Lunch _____ Dinner

Please indicate the foods you consume on **a typical day**

Meal	Food/Drink (amount)
Breakfast	
Morning Snack(s)	
Lunch	
Afternoon Snack(s)	
Dinner	
Evening Snack(s)	
Other	

What level of appetite do you usually have in the morning?

☐ None ☐ Very Low ☐ Low ☐ Moderate ☐ High

Approximately when do you usually eat for the first time? _____ **A.M.** **P.M**.

What % of your daily food intake do you consume after dinner? _____ %

Please use the 5 point scale below to rate the statements/questions.

1 – Never 2 – Sometimes 3 - Half the time 4 – Usually 5 – Always

_____ How often do you have trouble getting to sleep?
_____ How often do you snack in the middle of the night?
_____ How often do you have cravings/urges to snack after dinner, but before bedtime?
_____ How often do you have cravings or urges to snack when you wake up at night?
_____ How often do feel blue or down in the dumps?

When you are feeling blue, what time of day is your mood better? _____ Lowest? _____

_____
NAME

PHYSICAL ACTIVITY

To what extent do you enjoy physical activity?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Greatly

In the past year how many times have you participated in the following activities?

_____ Walking Outside	_____ Biking Outdoors	_____ Tennis/Racket Sports
_____ Walking Indoors	_____ Biking Indoors	_____ Swimming
_____ Jogging	_____ Aerobic Class	_____ Dancing
_____ Running	_____ Strength Training	_____ Other _____
_____ Golf	_____ Basketball	_____ Other _____

On average, how many city blocks (12 blocks = 1 mile) do you walk each day? _____

On average, how many flights of stairs (10 steps = 1 flight) do you climb up each day? _____

On a scale of 1 to 10 (1 = very sedentary and 10 = very active) rate your daily lifestyle activity level _____

TOBACCO AND ALCOHOL USE

Do you smoke cigarettes? **NO** ☐ **YES** _____/day How many years have you smoked? _____

Have you ever smoked cigarettes and stopped? **NO** ☐ **YES** _____ years smoked; _____ years since quit

Did you experience any weight gain after quitting? **NO** ☐ **YES** _____ pounds

How much alcohol (per week) did you consume in the last year?
Glasses wine per week? ____ Bottles/cans beer per week? _____ Mixed drinks/liquor per week? ____

Have you ever had a problem with alcohol or drugs (including prescription medication)?
NO ☐ **YES** _____

Is this a current problem? **YES** ☐ **NO -** years/months since quit _____ months years

How did you stop/reduce the problem? _____

_____

NAME

FAMILY AND LIVING ARRANGEMENTS

Please indicate your current relationship status:

☐ Single ☐ Married ☐ Long-term partner ☐ Divorced ☐ Separated ☐ Widowed

What is the total number of people living in your home? _____

If you are currently involved in a relationship, please answer the following questions.

1. On a scale of 1(very unhappy) to 10(very satisfied) rate your overall relationship with this person? _____

2. What is this person's attitude toward your efforts to adopt a healthier lifestyle?
   ☐ Strongly Opposes ☐ Opposes ☐ Neutral ☐ Supports ☐ Strongly Supports

3. Give specific examples of how he/she helps or hinders your efforts to be healthy (even unintentionally).

   _____

   _____

   _____

4. Are there others who support your efforts to change your lifestyle? **NO** ☐ **YES** _____
   Give specific examples of how they help your efforts to be healthy.

   _____

   _____

   _____

5. Are there others who hinder/oppose your efforts to change your lifestyle? **NO** ☐ **YES** _____
   Give specific examples of how they hinder your efforts to be healthy (even unintentionally).

   _____

   _____

   _____

6. Are there people you can talk with about your weight/body when you are upset by it? **NO** ☐ **YES** ☐
   How helpful is this? ☐ Very Unhelpful ☐ Unhelpful ☐ Neutral ☐ Helpful ☐ Very Helpful

_____
NAME

SELF PERCEPTIONS

In general, how important has your weight or shape been in how you feel about yourself as a person?

☐ Not very important
☐ Played a part in how I felt about myself
☐ An important influence in how I feel about myself
☐ The main influence in how I feel about myself

Pick the statement that best finishes each of the following sentences.

In general, I …
☐ am very happy with who I am
☐ am happy with who I am
☐ have mixed feelings about myself
☐ am unhappy with who I am
☐ am very unhappy with who I am

Compared with most people, I think I have…
☐ very good self-esteem
☐ good self-esteem
☐ average self-esteem
☐ poor self-esteem
☐ very poor self-esteem

The last time I lost a lot of weight, I was…
☐ very happy with the way I looked
☐ happy with the way I looked
☐ mostly happy with how I looked, but with mixed feelings
☐ unhappy with the way I looked
☐ very unhappy with the way I looked

STRESSORS

Please check any of the following areas in which you are currently experiencing stress.

☐ Work ☐ Health ☐ School ☐ Moving ☐ Legal ☐ Financial
☐ Children ☐ Parents ☐ Relationship ☐ Other: _____

Are you planning any major life changes (i.e. new job, moving, relationship, etc.) during the next 6 months? **NO** ☐
YES _____

On a scale of 1(no stress)to 10(extremely stressful) rate your life stress during the past 6 months. _____

Using the same scale above, rate how stressful you think your life will be in the next 6 months. _____

Do you have the ability to eat as needed/wanted during the day or are meal times limited (e.g., unable to eat during 3 hour classes, no food at workplace desk, etc.) _____
_____

_____

NAME

MOTIVATION

On a scale of 1 (not motivated) to 10 (very motivated), how motivated are you to change your lifestyle?_____

Compared to a year ago, why do you want make these changes now? _____

_____

What is the most important thing you hope to achieve as a result of losing weight? _____

_____

Choose the statement that best finishes the following sentence.
"I will…"

☐ ***not*** be able to devote 30 minutes daily to my new lifestyle changes

☐ probably be able to devote 30 minutes daily to my new lifestyle changes, but I am unsure

☐ definitely be able to devote 30 minutes daily to my new lifestyle changes

☐ devote more than 30 minutes daily to my new lifestyle changes

Please use the space below to discuss any other information that you think is important to understanding you and/or your weight and your successful participation in changing your eating and exercise habits.

_____

_____

_____

_____

_____

_____

_____