

Weight Loss Questionnaire

First Name: _____ Last Name: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ E-Mail: _____
Primary Contact #: Home Cell May I Leave a Message? Yes No
Age: _____ Date of Birth _____ Sex: M F Race _____
Marital Status: _____ If Single, are you in a Relationship? Yes No
Living With: _____ Number of Children: _____ Ages: _____
Occupation: _____ Employer: _____ For How Long? _____
Are you Happy at Work? Yes No
What other stressful issues are you currently dealing with?

Why do you want to lose weight?

I think my weight problem is due to:

I would like to lose approximately _____ pounds.

Approximate current weight: _____ Height: _____

At what age were you first overweight?

At what age did you first try to lose weight?

Have you ever been successful at any attempt to lose weight? Yes No

Describe prior attempts:

Have you ever been in counseling or worked with any other mental health provider?

Describe:

List any health problems you have:

List any medications you are taking:

Do you have any learning disabilities? Yes No

Describe:

Imagine that you are successful and are at the weight that you'd like to be. How would your life be different? What are the main benefits of losing weight for you?

Is there anything else you would like to change in your life or in yourself?

What would you want to make sure I understand about you in order to make sure I know you?
(If this is something that you only want to discuss in person, just write, "When we talk.")