Affinity Family Health Wellness

WEIGHT LOSS MANAGEMENT INTAKE QUESTIONS

Name _____ DOB _____

Address

_____

_____

_____

Phone Number _____

PERSONAL

Ideal/Desired Weight _____

What is the main reason for your desire to lose weight? _____

_____

In what time frame would you like to be at your desired weight? _____

How long have you been struggling with your weight? (Recent weight gain/Lifetime struggle) _____

_____

What diets and/or programs have you tried? (Atkins, South Beach, Jenny Craig, Weight Watchers)

_____

What medications have you tried? _____

Were any of them successful? Yes No

If Yes, which ones? _____

Is your spouse or partner overweight? Yes No

EATING HABITS

How often do you eat out? _____

What restaurants do you frequent? _____

How often do you eat “fast foods”? _____

Who plans meals? _____

Who cooks? _____

Who shops for food? Do you use a shopping list? _____

What foods do you crave? _____

Do you crave these foods at a specific time of the day or month? If so, when? _____

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What foods do you dislike? _____

Describe what you eat on a typical day

Breakfast:

_____

Lunch:

_____

Dinner:

_____

Snacks:

_____

Do you drink:

(Coffee or tea) How much daily?

_____

(Carbonated drinks) How much daily?

_____

(Alcohol) How much daily?

_____

Do you get up at night to eat? Yes No

_____

If Yes, why do you get up?

_____

What are your worst food habits? _____

_____

FITNESS

Do you work out or are you engaged in any type of physical activity? Yes No

What do you do? (Walk Run Swim Aerobics Weights Sports)

_____

How many times a week? (Less than 3, 3-5, More than 5)

_____

For how long? (Less than 20 minutes, 20-45 minutes, More than 45 minutes)

_____

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LIFESTYLE / PSYCHO-SOCIAL

Do you tend to eat more when you are under a stressful situation? Yes No

Are you currently going through a stressful situation? Yes No

Do you smoke? Yes No How many cigarettes per day? _____

Do you work outside the home? Yes No How many hours per week? _____

Do you work nights? Yes No

Is your job stressful? Yes No

If Yes, explain? _____

Have you been dealing with depression and/or anxiety? Yes No

Have you ever been treated for depression and/or anxiety? Yes No

If Yes, what medications have you used? _____

Is there any other information that is important for us to know in your weight loss journey? _____

_____

_____

_____

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BEDs-7 SCREENER

The following questions ask about your eating patterns and behaviors within the last 3 months.

For each question, choose the answer that best applies to you.

1. During the last 3 months, did you have any episodes of excessive overeating (i.e., eating significantly more than what most people would eat in a similar period of time)?

□**Yes** □**No**

NOTE: IF YOU ANSWERED "NO" TO QUESTION 1, YOU MAY STOP. THE REMAINING QUESTIONS DO NOT APPLY TO YOU.

2. Do you feel distressed about your episodes of excessive overeating?

□**Yes** □**No**

Within the past 3 months…

3. During your episodes of excessive overeating, how often did you feel like you had no control over your eating (e.g., not being able to stop eating, feel compelled to eat, or going back and forth for more food)?

□**Never or Rarely** □**Sometimes** □**Often** □**Always**

4. During your episodes of excessive overeating, how often did you continue eating even though you were not hungry?

□**Never or Rarely** □**Sometimes** □**Often** □**Always**

5. During your episodes of excessive overeating, how often were you embarrassed by how much you ate?

□**Never or Rarely** □**Sometimes** □**Often** □**Always**

6. During your episodes of excessive overeating, how often did you feel disgusted with yourself or guilty afterward?

□**Never or Rarely** □**Sometimes** □**Often** □**Always**

7. During the last 3 months, how often did you make yourself vomit as a means to control your weight or shape?

□**Never or Rarely** □**Sometimes** □**Often** □**Always**