Name
DOB

Adult Weight Management Questionnaire

Weight History

1. What do you consider a good weight for yourself? _____ Current Weight_____
2. What is the most you have weighed?_____ at what age?_____
3. What is the least you have weighed as an adult?_____ at what age?_____
4. Have you gained or lost weight recently?_____ How much?_____ Time frame_____
5. Is your spouse overweight?_____ Children?_____ Parents?_____ Siblings? _____
6. Are you overweight right now?_____
7. How long have you been overweight?_____

Related Factors

What do you see as your reason(s) for being overweight or overeating?

☐ type of food	☐ watching TV or movies	☐ comfort	☐ meat
☐ portions	☐ depression	☐ job	☐ convenience
☐ alcohol	☐ anger	☐ fatty foods	☐ lack of time
☐ snacks	☐ boredom	☐ sugar/sweets	☐ unplanned meals
☐ travel or eating out	☐ nervousness	☐ fast foods	☐ no support
☐ habits	☐ stress	☐ soft drinks	☐ conflicts
☐ socializing	☐ quit smoking	☐ desserts	☐ inconsistent meal times
☐ lack of food knowledge	☐ enjoy food	☐ escape	☐ other_____

How do others influence your weight loss goals? Give their names.

INFLUENCE	NAMES	HOW
Positive		
Negative		
Others		

List diets and/or weight-loss plans you have followed in the past: _____

_____

Which worked?_____

What is your biggest challenge regarding weight loss?

Why do you want to lose weight?

☐ Health	☐ Appearance
☐ Feel better	☐ Clothes fit better
☐ Improve physical fitness	☐ Pressure from family/friends
☐ Physician/Nutritionist advice	☐ Other:

Name
DOB

Why do you want to see a nutritionist and what are your goals?

Do you feel sad most days? ☐ Yes ☐ No
Do you have a decreased pleasure in normal activities? ☐ Yes ☐ No
Do you have difficulty sleeping or significantly increased need to sleep? ☐ Yes ☐ No
Do you feel guilty or worthless? ☐ Yes ☐ No
Do you have a low energy level? ☐ Yes ☐ No
Do you think of injuring yourself or others? ☐ Yes ☐No
Do you have difficulty making decisions or concentrating? ☐ Yes ☐No