

First Care Weight Loss and Wellness Personal Questionnaire

The following information is necessary for our staff to establish your needs during your weight loss program.

Please answer all questions to the best of your knowledge.

Date: _____ Counselor _____

Name: _____ DOB _____

SS# _____ Phone: (H) _____ (W) _____ (C) _____

Address : _____

City: _____ State: _____ Zip: _____

email address: _____

Age: _____ Height: _____ Occupation: _____

Employed by: _____

Referred by: _____

How did you hear about our weight loss program? _____

1. Does your extra weight make you feel uncomfortable? ___ Yes ___ No ___ Sometimes
2. Present Weight _____ Desired Weight _____
3. What was your heaviest weight? _____ When did you start to gain weight? _____
What size are you currently wearing? Dress or slacks? _____
4. What if anything, have you done previously to loss weight?
Exercise _____ Pills _____ Fasting _____ Diet _____ If diet, where? _____
5. How successful were you? Very successful _____ Successful _____ Average _____ Poor _____
6. Have you gained weight since then? Yes _____ No _____
7. How many pounds per week do you lose when you diet? _____
8. Do you take vitamins or other food supplements when you diet? Yes _____ No _____
- 9.. Do you prefer fast foods? Yes _____ No _____
10. Which describes you best? I eat too much: when nervous _____ for pleasure _____ when upset _____
11. Do you take the time to plan and cook your meals? Yes _____ No _____
12. How do you reward yourself for dieting? _____
13. Have you ever felt tired or hungry while dieting? Yes _____ No _____
14. What does your doctor think of your weight? _____ I should lose _____ You shouldn't _____ No opinion
15. Do those close to you wish you would take part in a weight loss program? Yes _____ No _____
If yes, who _____
16. Did anyone ever encourage you during a diet before? Yes _____ No _____ If yes, who? _____
17. Is your dieting more successful when friends or family members diet with you? Yes _____ No _____
18. How important do you think it is to have a diet partner? Very _____ Not very _____ No opinion _____
19. Does your schedule allow you a few minutes once or twice a week to visit our center? Yes _____ No _____
20. Why is it important for you to lose weight fast? Appearance _____ Doctor's Suggestion _____ Tight Clothes _____
Upcoming event _____ General Health _____ Self-esteem _____ Other _____

If other, please explain _____

Are you taking insulin for diabetes? _____

Notes: _____