American Health & Wellness Center

Nutritional Counseling Questionnaire

Name: _____ **Date:** ____/____/_____
E-Mail address: _____ **Age:** _____
Phone number: _____ **Height:** _____

Weight: _____ **Goal Weight:** _____

Please complete the questionnaire to the best of your ability!

1. Is there a reason you are seeking treatment at this time?

_____

2. What are your goals regarding weight control and management? _____

_____

_____

3. Your level of interest in losing weight is:
Not interested 1 2 3 4 5 Very Interested

4. Are you ready for lifestyle changes to be a part of your weight control program?
Not ready 1 2 3 4 5 Very Ready

5.How much support can your family provide?
No Support 1 2 3 4 5 Much Support

6. How much support can your friends provide?
No Support 1 2 3 4 5 Much Support

7.What is the hardest part about managing your weight? _____

_____

8. How confident are you that you can lose weight at this time?
Not Confident 1 2 3 4 5 Very Confident

_____

Weight Restriction History

9. Do you currently follow any dietary restrictions? Explain._____

_____

_____

10. At what age did you start trying to lose weight? _____

11. Please check all previous programs you have tried in order to lose weight

Program	**Weight loss/gain**	**Length of Participation**
TOPS	_____	_____
Weight watchers	_____	_____
Overeaters Anonymous	_____	_____
Liquid Diet	_____	_____
Diet Pill: Meridia, Xenica	_____	_____
Diet Pill: phen-fen, Redux	_____	_____
NutriSystem/ Jenny Craig	_____	_____
OTC diet oils	_____	_____
Obesity Surgery	_____	_____
Registered Dietritian	_____	_____
Other	_____	_____

12. Have you maintained any weight loss for up to 1 year on any of these programs?
Yes ☐ No ☐

13. What did you learn from these programs regarding your weight? _____
_____
_____

14. What did not work about these programs? _____
_____
_____

15. During these programs were you involved in any physical activity programs or exercise routines? Explain. _____
_____
_____