The University of Texas at Dallas: Employee Wellness Center

Weight Management Questionnaire

Patient Name _____ Date_____

Please answer each of the questions below. The information you share will help the Registered Dietitian have a better understanding of your needs.

1. Are you concerned about your weight?
   - ☐ No (Skip to question 4)
   - ☐ Yes, I want to stop gaining weight. (Skip to question 4)
   - ☐ Yes, I want to lose weight.

2. What do you think weighing less would do for you?

   In the next few months:

   _____

   _____

   _____

   _____

   In the next year or two:

   _____

   _____

   _____

   _____

3. What is your goal weight? _____lbs.

4. What was your lowest adult weight? _____ Age at this weight? _____

   What was your highest adult weight? _____ Age at this weight? _____

5. Do you take any vitamin, mineral, herbal, or other dietary supplements (for example protein powders?)
   - ☐ Yes List _____

     _____
   - ☐ No

6. Do you smoke cigarettes?
   - ☐ Yes – How many in a typical day? _____
   - ☐ No

7. Are you currently on a diet or taking prescribed or across-the-counter medication to lose weight or to maintain your current weight?
   - ☐ No
   - ☐ Yes, I am on a diet. Describe the diet:

     _____

     _____

     _____

   - ☐ Yes, I am taking medications. List medications:

     _____

     _____

     _____

     _____

8. Have you tried to lose weight in the past?
   - ☐ No (Skip to Question 10.)
   - ☐ Yes – check all that apply.
     - o Diet(s) Describe.

       _____

       _____

     - o Medications List.

       _____

       _____

     - o Other – Describe.

       _____

       _____

9. If yes to number 8, did you lose weight?
   - ☐ No
   - ☐ Yes _____ lbs. over this period of time _____

     How much of this weight, if any, did you gain back? _____ lbs.

     What worked best for you and why?

     _____

     _____

     _____

10. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pills or laxatives, or not eating?
    - ☐ Yes
    - ☐ No

11. Do you ever feel that your eating is out of control?
    - ☐ No
    - ☐ Yes – explain:

    _____

    _____

    _____

12. Do you participate in regular physical activity?
    - ☐ No (Skip to question 13.)
    - ☐ Yes – Describe

LIST YOUR ACTIVITIES	HOW MANY TIMES A WEEK DO YOU DO THIS ACTIVITY?	HOW MUCH TIME DO YOU SPEND IN THIS ACTIVITY IN A TYPICAL WEEK?
1.		
2.		
3.		
4.		
5.		
6.		

13. Put an X on the line below to show on a scale from 0 to 10, how important it is for you to make lifestyle changes? (**Lifestyle changes** are changes to improve your health, such as adjusting your diet, increasing your physical activity, and changing health-related behaviors.)

……
0 5 10

Not very important **Somewhat important** **Very important**

14. Put an X on the line to show how ready you are right now, on a scale of 0 to 10, to make lifestyle changes.

....……

0	5	10
Not Very Ready	**Somewhat ready**	**Very ready**

15. Put an X on the line to show how confident you are, on a scale of 0 to 10, that you can make lifestyle changes?

....……

0	5	10
Not Very confident	**Somewhat confident**	**Very confident**

16. What lifestyle changes would you be willing to make?

_____

_____

_____

_____

_____

17. How much time would you be willing to spend each week on making lifestyle changes? (for example attending classes, reading info, tracking foods eaten and activity)

_____

18. What things might make it hard for you to make lifestyle changes?

_____

_____

_____

_____

_____

19. Put an X on the line to show your current level of stress, on a scale of 0 to 5.

....……

0	3	5
Very Relaxed	**Managing OK**	**Very stressed**

20. Describe your family – the number of people who live with you and their relationship to you.
    - ☐ Husband, wife, or partner
    - ☐ Children – How many _____, ages _____
    - ☐ Other – Describe:

      _____

      _____

21. Check any that apply:
    - ☐ My family eats most meals together.
    - ☐ Family meals are served at regular times on most days.
    - ☐ My family is supportive of my efforts to lose weight.
    - ☐ Another member of my family is on special diet or is trying to lose weight. Describe

      _____

      _____

22. Check the types of food you and your family eats and how many times in a typical week:
    - ☐ Heat and serve meals _____
    - ☐ Home cooked meals _____
    - ☐ Fast foods _____
    - ☐ Take out from grocery or restaurant _____

23. Do you have a working stove, oven, and refrigerator where you live?
    - ☐ Yes
    - ☐ No Explain_____

24. Were there any days last month when your family didn't have enough to eat or enough money to buy food?
    - ☐ No
    - ☐ Yes

Please check to be sure you have answered all questions, and bring this with you to your appointment. Thank you!