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

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

<table>
<thead>
<tr>
<th>INFLUENCE</th>
<th>NAMES</th>
<th>HOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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
- Feel better
- Improve physical fitness
- Physician/Nutritionist advice
- Appearance
- Clothes fit better
- Pressure from family/friends
- Other:
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you feel sad most days?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have a decreased pleasure in normal activities?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have difficulty sleeping or significantly increased need to sleep?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you feel guilty or worthless?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have a low energy level?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you think of injuring yourself or others?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have difficulty making decisions or concentrating?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>