Health and Lifestyle Questionnaire

Your health, well-being and weight are influenced by many different things, including lifestyle, family history, emotional health, nutrition, eating and exercise habits. Please complete this questionnaire to help us design the best possible program to support your weight loss and wellness efforts.

GOALS AND READINESS ASSESSMENT

This is how I describe my current state of health:

______________________________________________________________________________
______________________________________________________________________________

What are the main reasons you want to lose weight?

______________________________________________________________________________
______________________________________________________________________________

What is the biggest challenge to reaching your weight loss and nutrition goals?

______________________________________________________________________________
______________________________________________________________________________

How would your life be different if you achieved your weight loss goal?

______________________________________________________________________________
______________________________________________________________________________

On a scale of 1 (not willing) to 5 (very willing), please indicate your readiness/willingness to do the following:

<table>
<thead>
<tr>
<th>To improve my health and lose more weight I am ready/willing to...</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significantly modify my diet</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Keep a food record of everything I eat and drink each day</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice portion control</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modify my lifestyle (i.e. sleep habits, physical activity, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Take nutritional supplements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Be physically active everyday</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work with my dietitian and keep all my appointments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PERSONAL MEDICAL HISTORY

Height: ___’___”  Weight: ______

What do you think is a realistic weight for you and one that you can maintain?_________

How long has it been since you were at that weight?____________

Please list any physician-diagnosed conditions you have:

______________________________________________________________________________
______________________________________________________________________________

LIFESTYLE

Physical Activity: Please describe your physical activity below

<table>
<thead>
<tr>
<th>Activity</th>
<th>Type/Intensity (low-moderate-high)</th>
<th># Days Per Week</th>
<th>Duration (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stretching</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jogging, biking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strength-training or weight lifting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sports</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Does anything limit you from being physically active? Yes____ No____

Sleep: On average, how many hours of sleep do you get? Weekdays____ Weekends____

Alcohol use: Never_____ In the past____ Currently___ Type/amount/frequency

______________________________________________________________________________

Do you drink regular soda pop? If so, how much? ________________________________
CULINARY ASSESSMENT

Do you follow any special diet or have diet restrictions/limitations for any reason (health, cultural, religious)?

Yes____ No____ If yes, please describe:
_______________________________________________________________________

What meals do you eat regularly? Check all that apply.

Breakfast_____ Lunch_____ Dinner_____ snacks
(times:______________________________________________)

Eating Style: Based on how you eat on a regular basis, check all that apply:

_____ fast eater____ emotional eater (stressed, bored, sad, etc.)  _____ late night eater
_____ dislike “healthy” food

_____Travel frequently _____do not plan meals _____rely on convenience items
_____family member(s) have different taste _____love to eat _____eat too much _____eat because I have to
_____struggle with eating issues _____poor snack choices

Grocery Shopping and Meal Planning:

Who does the majority of the shopping? ___________________________________________

Who prepares the majority of your meals? ___________________________________________

Check the answer that best applies to you:

_____ I plan meals for the week _____ I plan meals 2-3 days ahead of time  _____ I plan dinner at
breakfast time

_____ I plan dinner on the way home from work/school _____ I plan dinner while I’m in the store
 _____ I don’t plan at all; just grab whatever I am in the mood to eat
**Eating Out**

How many times on average do you eat out during the week?
___________________________________________________________________________

Meals you usually eat out? breakfast lunch dinner

Types of restaurants you eat at?
___________________________________________________________________________

Give examples of items you order when eating out:
___________________________________________________________________________
___________________________________________________________________________

Typical foods you might eat over the course of a day include:

**Breakfast:**

**Lunch:**

**Dinner:**

**Snacks:**