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

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<thead>
<tr>
<th>LIST YOUR ACTIVITIES</th>
<th>HOW MANY TIMES A WEEK DO YOU DO THIS ACTIVITY?</th>
<th>HOW MUCH TIME DO YOU SPEND IN THIS ACTIVITY IN A TYPICAL WEEK?</th>
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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?

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........................................................................................................................................
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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)

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

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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!