

Weight Management Assessment

This form will help guide our session(s) together. Please give yourself time to fill it out as completely as possible.

First Name: _____ Last Name: _____ Date: _____

Current Weight: _____ Height: _____ Goal Weight: _____

Have you always had a hard time managing your weight? Or is this a more recent challenge? Explain: _____

What have you tried in the past? _____

What is motivating you to manage your weight? _____

How will you feel when you reach your target weight? _____

Do you have any upcoming stresses, events, vacations, or occasions that might make changing your habits challenging? _____

Check all medical conditions that apply: high blood pressure, high cholesterol, diabetes hypoglycemia
 other weight-related health concerns: _____

Have you ever been diagnosed with an eating disorder? If so, please explain: _____

Check all that apply. I usually treat myself to a snack or a meal whenever I need... love, comfort, a reward, companionship, something to do, a change in my activity to relax, to feel secure, to compensate for something unpleasant

Check all that apply. I usually eat when I am... hungry, nervous, sad, bored, stressed, happy, sad, lonely, frustrated, afraid, other: _____

Check all that apply. I usually snack ... while working, while watching TV, while reading, during breaks, while socializing, after dinner, in bed, other: _____

Check all that apply. Food equals love. If you care about someone, you feed them. It is disrespectful not to eat food that is offered. Leaving food on the plate is wasteful. I don't have time to eat properly. A meal isn't complete without dessert. I don't have time to exercise.

Do you eat breakfast? (Be sure to address both your weekday and your weekend habits below.)

Yes. What do you typically eat and drink at breakfast? _____

No. Explain. _____

Sometimes. Explain. _____

Do you tend to overeat at breakfast? Yes. No. _____

Are there changes you would like to make regarding your breakfast-eating habits? If so, what is your goal?

What challenges might prevent you from making these changes?	What do you need to do to overcome these challenges?

What is the benefit will you gain from having the breakfast-eating habits you desire? _____

Do you eat lunch? (Be sure to address both your weekday and your weekend habits below.)

Yes. What do you typically eat and drink at lunch? _____

No. Explain. _____

Sometimes. Explain. _____

Do you tend to overeat at lunch? Yes. No. _____

Are there changes you would like to make regarding your lunch-eating habits? If so, what is your goal?

What challenges might prevent you from making these changes?	What do you need to do to overcome these challenges?

What is the benefit will you gain from having the lunch-eating habits you desire? _____

Do you eat dinner? (Be sure to address both your weekday and your weekend habits below.)

Yes. What do you eat and drink at dinner? _____

No. Explain. _____

Sometimes. Explain. _____

Do you tend to overeat at dinner? Yes. No. _____

Are there changes you would like to make regarding your dinner-eating habits? If so, what is your goal?

What challenges might prevent you from making these changes?	What do you need to do to overcome these challenges?

What is the benefit will you gain from having the dinner-eating habits you desire? _____

Do you have a sweet tooth? Yes No Sometimes

How often do you eat sweets and desserts? on occasion, every day, more than once a day

When do you typically eat sweets and desserts? _____

Do you have a weakness for specific sweets and desserts? List them: _____

A realistic goal for consumption of sweets and desserts: _____

Do you overindulge in unhealthy snacks besides sweets? Yes No Sometimes

When do you typically snack? _____

Do you have a weakness for specific unhealthy snacks? List them: _____

Realistic goal(s) for unhealthy snack consumption: _____

List healthy snacks that you enjoy: _____

What beverages do you often drink? soda, diet soda, coffee, specialty coffee drinks, tea, water, sparkling water, juice, smoothies, beer, wine, cocktails, spirits, other: _____

Are you concerned that your beverage consumption may contribute to weight gain? _____

Do you feel you drink enough water every day? Yes No

A realistic goal for beverage consumption: _____

How often do you exercise? never to hardly ever 1-2 times a week 2-3 times a week 3-4 times a week 4-5 times a week more than 5 times a week

What kind of exercise do you do? _____

Realistic goals for exercise. What kind of exercise would you like to do and how often? Be specific about days and times. _____

What challenges might prevent you from reaching your exercise goals?	What do you need to do to overcome these challenges?

What are healthy ways you cope with stress? _____

Is there anything else you feel would be helpful for me to know? _____