PEAK HEALTH FAMILY MEDICINE

*Name*_____*Date*_____ *Date of Birth*_____

Questions for 1st Weight Loss Visit

Please take a moment to fill out this form prior to your first weight loss visit. You may either PRINT this to bring completed to your first visit

1. Are you currently following a diet? If yes, explain: _____
2. Circle the meals you eat regularly: breakfast lunch dinner
3. Circle the time of day you snack: morning afternoon evening N/A
4. How many times/**week** do you eat out (restaurant/fast food)? _____
5. How many times/**day** do you eat the following:_____
    a. Starches (breads, cereal, pasta, potatoes, rice, etc.) _____
    b. Fruit _____
    c. Vegetables _____
    d. Milk, yogurt, cheese _____
    e. Meat, poultry, fish _____
    f. Fats (butter/margarine, oils, mayonnaise, salad dressings) _____
    g. Sweets (regular soda, candy, cakes, cookies, etc.) _____
6. How many ounces/**day** do you drink of the following:
    a. Water _____
    b. Coffee _____
    c. Tea _____
    d. Juice _____
    e. Soda (specify diet or regular) _____
    f. Alcohol (specify type) _____
    g. Other: _____
7. How many minutes/**week** do you do the following:
    a. Cardio exercise (walking, swimming, running, cycling, etc.) _____
    b. Strength Training _____
8. Have you struggled with an eating disorder in the past? yes no
    a. If yes, please explain: _____
9. From 1-10 (10 being the highest score), how would you rank the support you will get from friends and family? _____
10. What is motivating you to lose weight at this time? What are your goals? _____
    _____
11. What has been your greatest struggle with weight loss in the past? _____
    _____

We look forward to seeing you!

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