Weight Loss Intake Sheet

Name: _____ Date: _____

1. Are you 18 years of age or older? Yes No

2. Why do you want to lose weight?

3. On a scale of 1 to 10 how strong is your desire to lose weight? Circle **Weak** 1 2 3 4 5 6 7 8 9 10 **Strong**

4. What would it take to make it a 10 and keep it there?

5. What is your current weight?

6. What is your goal weight?

7. Enter your weight loss goal: _____

8. Are you currently under a doctor's care? Yes No If so please describe the nature of that care.

9. Please list any medications you are taking, prescription or over the counter:

10. At what age did you first develop a weight problem? _____

11. Have you successfully lost weight in the past? Yes No

12. If you have lost weight before what techniques or methods did you find helpful?

13. What techniques or methods have you tried that you have found unhelpful?

14. If you have lost weight and regained it what do you think caused you to regain the weight?

15. At what time of the day do you tend to overeat most?

16. Please list any triggers or foods that may cause you to overeat (such as low blood sugar, skipping a meal, certain foods like pizza or sweets, watching television, etc)

17. What would your life be like if you lost the weight you desire to lose?

18. What do you have to lose if you lost the extra weight?