Weight Loss Questionnaire

1. What's the main reason you are seeking treatment at this time?

   _____

2. What are your goals about weight control and management?

   _____

3. Your level of interest in losing weight is:

   1 2 3 4 5

   Not interested Very Interested

4. Are you ready for lifestyle changes to be a part of your weight control program?

   1 2 3 4 5

   Not Ready Very Ready

5. How much support can your family provide?

   1 2 3 4 5

   No Support Much Support

6. How much support can your friends provide?

   1 2 3 4 5

   No Support Much Support

7. What is the hardest part about managing your weight?

   _____

8. What do you believe will be the most helpful in helping you to lose weight?

   _____

9. What has been your lowest and highest body weight as an adult?

   Lowest: _____ Highest: _____

10. Please check all previous programs that you have tried in order to lose weight.
    Indicate dates and length of and any current medications.

Program	**Date**	**medication**	**Dose/freq.**
Weight Watchers			
Liquid Diets			
Keto Diet			
Diet Pills (Phen-Fen)			
Nutrisystem/Jenny Craig			
Obesity Surgery			

11. Have you maintained any weight loss for up to 1 year at any of these programs? ☐ Yes ☐ No

12. What did you learn from these programs regarding your weight?

_____

13. What did not work about these programs, so we can make changes?

_____

14. How important is it that you lose weight at this time?
    a. Not
    b. Not Very
    c. Somewhat
    d. Very Important
    e. Imperative

15. What factors led to your success?
    a. Encouragement from others
    b. Determination
    c. Goal – Event with old friends, etc.

16. How does being overweight affect you?
    a. Limits exercise
    b. Can't wear my clothes
    c. Tired all the time
    d. My knees hurt
    e. My back hurts

17. What has made weight loss difficult?
    a. Travel
    b. Holidays
    c. Weekends
    d. Parties
    e. Hunger
    f. Cost of Care
    g. Peer Pressure
    h. Family

19. What is hard about managing your weight?
    i. No will power
    j. I've always been overweight
    k. No exercise
    l. Schedule too busy
    m. Hungry all the time
    n. I don't like vegetables
    o. I'm a meat and potatoes person

20. What beverages do you drink daily and how much?

Drink	**Times or 8 oz. glasses per day**
Water	
Coffee	
Tea	
Soda	
Alcohol	
Other:	

21. Would you like to change your eating habits? Yes ☐ No ☐

22. What habits would you like to begin to change?

23. Is your decision to lose weight your own or for someone else?
    a. Mine
    b. My wife
    c. My husband
    d. My parents
    e. My friends

24. Is your family supportive? Yes ☐ No ☐

25. What can't you do now that you would like to do if you weighed less?
    a. Keep up with partner
    b. General activity
    c. Play golf
    d. Go for walks
    e. Play with my children/grandchildren
    f. Get into my old clothes

26. What would you like to get out of this visit regarding your weight?
    a. A diet
    b. Accountability
    c. Understanding about what makes me heavy
    d. Lasting change

What's more important inches lost or pounds ?		
Does being overweight and unhealthy limit your activities?	□ Yes	□ No
Do you binge eat?	□ Yes	□ No
Do you suffer from uncontrollable cravings?	□ Yes	□ No

Do you feel that food controls you?	□ Yes	□ No
Do you eat because of your emotions?	□ Yes	□ No
Do you eat between meals?	□ Yes	□ No
How much weight do you want to lose?		
Do you feel that your eating behaviors are normal?	□ Yes	□ No
Briefly describe your daily eating behaviors:		
Do you feel tired, run down, or out of energy?	□ Yes	□ No
Is successful weight loss a top priority?	□ Yes	□ No
Please explain:		
How fast do you want to be slim, trim, and fit?		
What's more important to you: fast or permanent?		
Does your family support your weight loss efforts?	□ Yes	□ No
Is your family excited that you're working with us?	□ Yes	□ No
Can you remember being at your ideal weight?	□ Yes	□ No
What do you remember most about it?		
What would stop you from a weight loss program?		
Commitment to weight loss: please rate 1 2 3 4 5 6 7 8 9 10		

Check the following conditions you would like help with or more information on:

□ Lipo Laser Fat Loss	□ fat Loss Injections	□ Libido/ Sex drive	□ Hormone Balance for Men
□ Hormone Balance for Women	□ Massage	□ Fatigue	□ Memory & Mood
□ Neck or Back Pain	□ Pain Relief	□ Quitting Smoking	□ Thyroid

What is the most important element in deciding to use our services?

Circle only ONE of the four answers:

EFFECTIVENESS: "My results are my top priority."
TIME: "I want results quickly."
SERVICE: "I need extra support along the way."
AFFORDABILITY: "I need this to be affordable.

Signature: _____ Date: _____

Patient Name: _____ **Date:** _____

Current Medical Providers: _____

Medical history

- ❑ Osteoporosis
- ❑ Heart disease
- ❑ Diabetes
- ❑ Cancer
- ❑ Depression
- ❑ Stroke
- ❑ Parkinson's disease
- ❑ Alcoholism
- ❑ Anemia
- ❑ Arthritis
- ❑ Anorexia
- ❑ Multiple sclerosis
- ❑ Migraine headaches
- ❑ Rheumatoid arthritis
- ❑ Thyroid problems
- ❑ Asthma
- ❑ Appendicitis
- ❑ Bleeding disorders
- ❑ Breast lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Chemical dependency
- ❑ Emphysema epilepsy
- ❑ Fractures
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herniated disc
- ❑ High cholesterol
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Miscarriage
- ❑ Pacemaker
- ❑ AIDS/HIV
- ❑ Pinched nerve
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate problems
- ❑ Psychiatric care
- ❑ Suicide attempt
- ❑ Tumor
- ❑ Ulcers
- ❑ Vaginal infection
- ❑ Venereal disease
- ❑ Whiplash
- ❑ Previous chiropractic care
- ❑ Herniated
- ❑ Low Back Pain
- ❑ Neck Pain
- ❑ Shoulder Pain
- ❑ Wrist Pain
- ❑ Elbow Pain
- ❑ Knee Pain
- ❑ Hip Pain
- ❑ Ankle Pain
- ❑ Fibromyalgia
- ❑ Multiple Sclerosis
- ❑ Balance Issues
- ❑ Vertigo
- ❑ Anxiety
- ❑ Sinusitis
- ❑ Allergies
- ❑ Headaches
- ❑ TMJ

Family health history

- ❑ Osteoporosis
- ❑ Cancer
- ❑ Heart disease
- ❑ Stroke
- ❑ Diabetes
- ❑ Kidney disease
- ❑ Depression
- ❑ Parkinson's disease
- ❑ Alcoholism
- ❑ Arthritis
- ❑ Anemia
- ❑ Anorexia
- ❑ Multiple sclerosis
- ❑ Migraine headaches
- ❑ Rheumatoid arthritis
- ❑ Thyroid problems
- ❑ Asthma
- ❑ Appendicitis
- ❑ Bleeding disorders
- ❑ Breast lump
- ❑ Bulimia
- ❑ Bronchitis
- ❑ Chemical dependency
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Hepatitis
- ❑ Fractures
- ❑ Hernia
- ❑ Herniated disc
- ❑ High cholesterol
- ❑ Liver disease
- ❑ Miscarriage
- ❑ Pacemaker
- ❑ AIDS/HIV
- ❑ Pinched nerve
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate problems
- ❑ Suicide attempt
- ❑ Tumors
- ❑ Ulcers
- ❑ Vaginal infection
- ❑ Venereal disease
- ❑ Whiplash

For office use only

Height _____ Weight _____ Waist Circumference _____ BP _____ / _____

Activities of Daily Living

What activities cause difficulty or pain?

- ❑ Sleeping
- ❑ Yard work
- ❑ Walking short distances
- ❑ Repetitive motions
- ❑ Bending for long periods
- ❑ Almost any movement
- ❑ Changing positions
- ❑ Lifting
- ❑ Extended computer use
- ❑ Pulling
- ❑ Walking
- ❑ Pushing
- ❑ Sitting
- ❑ Carrying
- ❑ Driving
- ❑ Getting out of bed
- ❑ Reaching
- ❑ Climbing stairs
- ❑ Twisting
- ❑ Turning
- ❑ Bending
- ❑ Kneeling
- ❑ Squatting
- ❑ Running
- ❑ Coughing and sneezing
- ❑ Working
- ❑ Gardening
- ❑ Cleaning
- ❑ Getting out of Bed
- ❑ Putting on Socks
- ❑ Overhead Lifting
- ❑ Lifting Kids
- ❑ Lifting more than 40 lbs.
- ❑ Getting comfortable
- ❑ Lying down
- ❑ Sitting

Provider: _____