Deaconess
WEIGHT LOSS
SOLUTIONS

Name _____ CSN (office use only) _____

Date of Birth _____ MRN (office use only) _____

NUTRITION ASSESSMENT QUESTIONNAIRE

Welcome to Deaconess Weight Loss Solutions. We look forward to supporting you in your journey to better health through weight loss. Please answer all of the following questions. If a question does not apply to you, answer with N/A.

GENERAL INFORMATION

Why are you seeking a weight loss program?

_____

_____

_____

_____

What lifestyle changes will you need to make to have success in your weight loss journey?

_____

_____

_____

_____

How do you see yourself benefitting from successful weight loss?

_____

_____

_____

_____

METHOD

Please put a check mark by your preferred method of weight loss.

☐ Gastric Bypass
☐ Sleeve Gastrectomy
☐ Non-Surgical Healthy Eating and Living Program

SPECIAL DIETS

Are you currently on a special diet? ☐ YES ☐ NO

If yes, who prescribed it? _____

What is your currently prescribed diet

☐ Low fat ☐ Low Salt
☐ Carbohydrate Controlled
☐ Other _____

FOOD ALLERGIES

Please list any food allergies or intolerances: (e.g., lactose intolerance, shellfish, gluten, etc.)

_____

_____

_____

_____

EATING DISORDERS

Have you ever received treatment for any of the following conditions?

☐ **YES** ☐ **NO** Anorexia nervosa
☐ **YES** ☐ **NO** Bulimia nervosa
☐ **YES** ☐ **NO** Binge-eating
☐ **YES** ☐ **NO** Purging after meals
☐ **YES** ☐ **NO** Other

_____

If you answered yes to any of the above, please list treatment received and the date of treatment:

_____

_____

_____

☐ **YES** ☐ **NO** Have you ever used laxatives to control your weight?

If yes, how often?

_____

☐ **YES** ☐ **NO** Do you find yourself eating large amounts of food when alone?

If yes, please describe eating episodes:

_____

_____

EATING ISSUES

☐ **YES** ☐ **NO** Wake up in the middle of the night and eat

☐ **YES** ☐ **NO** Wake up in the morning to find evidence that you have eaten, but you don't remember the episode

☐ **YES** ☐ **NO** Frequently skip meals

☐ **YES** ☐ **NO** Frequently crave sweets during the day

☐ **YES** ☐ **NO** Frequently fast as a part of your diet plan

☐ **YES** ☐ **NO** Are a vegetarian (check one):
☐ Vegan ☐ Vegetarian
☐ Octo-lacto ☐ Octo ☐ Lacto

☐ **YES** ☐ **NO** Drink alcoholic beverages (If yes, how often do you drink?)

_____

☐ **YES** ☐ **NO** Feel that there are foods that you cannot live without

☐ **YES** ☐ **NO** Experience problems with chewing or swallowing

If you checked yes on any of the above, please explain:

_____

_____

_____

_____

ENVIRONMENTAL ISSUES THAT AFFECT YOUR WEIGHT

☐ **YES** ☐ **NO** Occupational (working around food/no time for lunch)

☐ **YES** ☐ **NO** Sleep

☐ **YES** ☐ **NO** Travel

☐ **YES** ☐ **NO** Household (family/obligations/schedule)

☐ **YES** ☐ **NO** Shopping or cooking

☐ **YES** ☐ **NO** Meals eaten away from home

If you checked yes on any of the above, please explain:

_____

_____

_____

_____

PLEASE CHECK ALL THAT APPLY

I get my groceries at:

☐ Grocery Store ☐ Food Banks
☐ Convenience Store ☐ Farmer Market

☐ **YES** ☐ **NO** Do you have a good food supply (meat, fruits, vegetables, milk) for the month?

If you DO NOT have a good food supply for the month, how long does your food supply last?

☐ 3 weeks ☐ 2 weeks ☐ 1 week

If you do not have an adequate food supply for the entire month, what do you do?

_____

_____

_____

SUPPORT STRUCTURE

List the people who will be there to support you during your weight loss journey.

_____

_____

_____

_____

_____

_____

****

WOMEN ONLY

☐ **YES** ☐ **NO** History of infertility

☐ **YES** ☐ **NO** Plans to become pregnant

FOOD INTAKE HISTORY

Please list your food intake for the past 24 hours if it has been a typical day. If the past 24 hours have not been typical regarding meal patterns, then describe a typical day.

Breakfast	Lunch	Dinner
Mid-morning snack	Mid-afternoon snack	Bedtime Snack

DIET HISTORY

How long have you been overweight or obese? _____

Were you overweight as a child? _____

How much weight do you want to lose? _____

PLEASE ENTER INFORMATION ON WEIGHT LOSS PROGRAMS YOU HAVE ATTEMPTED PREVIOUSLY

Types of Diet Programs or Methods of Losing Weight	Dates From	To	Weight Lost	Weight Regained
Acupuncture				
Antidepressants				
Bariatric (Gastric) Surgery				
Diet Pills — Over-the-Counter				
Diet Pills — Prescription				
Diet Shots (HCG, B-12, Diuretics)				
Jenny Craig				
Weight Watchers				
Slim-Fast/Medifast/Opti-Fast (Meal Replacement Programs)				
Beach Body				
Mayo Clinic Diet				
Ketogenic Diet				
Mediterranean Diet				
Flexitarian Diet				
Anti-Inflammatory Diet				
Dash Diet				
South Beach Diet				
Profile by Sanford				
Overeaters Anonymous				
Nutritionist/Dietitian				
Therapy/Counseling				
Weight Program Directed by a Doctor				
List any other weight loss plans other than those above that you have used to try to lose weight. **Use back of form if more space is needed.**				

READINESS FOR CHANGE

	Weight Loss: Check the statement below that BEST pertains to you right now
	I do not plan to make changes in my dietary intake in the next six months.
	I do plan to make changes in my dietary intake in the next six months.
	I do plan to make changes in my dietary intake in the next month.
	I have made positive changes in my dietary intake over the last six months.
	I have made positive changes in my dietary intake for more than six months.
	I made positive changes in my dietary intake for more than six months but stopped.
	Exercise: Check the statement below that BEST pertains to you right now
	I do not plan to make changes in my exercise routine in the next six months.
	I do plan to make changes in my exercise routine in the next six months.
	I do plan to make changes in my exercise routine in the next month.
	I have made positive changes in my exercise routine over the last six months.
	I have made positive changes in my exercise routine for more than six months.
	I made positive changes in exercise routine for more than six months but stopped.

EXERCISE QUESTIONNAIRE

Developing an active lifestyle is one of the most important changes that must take place for weight loss success and long-term weight maintenance. Exercise is any type of physical activity above and beyond what is required for your daily routine. Almost everyone can perform some type of exercise, but the key is consistency!

Name: _____

Date: _____

Do you have any doctor-ordered restrictions on exercise?

What is currently limiting your physical activity?

Do you have a current exercise routine?
*(Please provide what type of activity, how many minutes performed and how many **consistent** days per week.)*

What type of exercise have you performed in the past that helped you with weight loss?

Do you have a gym membership, and are you likely to use it?

What type of exercise equipment is available to you at home?

On a scale from 1 to 10, how motivated to exercise are you? *(One being not at all motivated and ten being highly motivated.)*

1 2 3 4 5 6 7 8 9 10

If you are not currently exercising, do you have a plan to get started? If so, please explain.