



Wellness Questionnaire

Section 1- Your Weight History

1. What is motivating you to lose weight right now?

2. Briefly describe your weight history.

3. History of weight loss programs, medications, or surgery.

4. What is your ideal weight: _____ Ideal dress size _____?
5. Least you have weighted your adult life and when.

6. Most you have weighted your adult life and when

Section 2 – Your Nutritional Habits

1. On a scale of 1 – 10 (1 being very low quality, 10 being very high quality), how would you assess the quality of your diet? _____
2. Do you follow any particular diet?
Please check all that apply.
 Vegetarian Low carb Low fat
 Other _____
3. Do you eat breakfast everyday?
 Yes No
4. How many meals do you eat in a day? _____
5. Do you snack throughout the day?
 Yes No
If yes, what do you like to snack on?

6. Do you find yourself skipping meals often?
 Yes No
If yes, which meal(s): _____
7. Approximately how many cups of fruit and vegetables do you consume everyday?
 less than 2 2-4 5 or more
8. How much soda/pop do you drink in a day? _____
9. How much water do you drink in a day? _____
10. Do you typically choose whole grain food sources versus refined food sources (i.e. brown rice vs. white rice)?
 Yes No
11. Are you consciously limiting the intake of any of the following:
 Salt Saturated fat Caffeine
 Cholesterol Red meats Trans fats
 Fried foods Sugar
12. How many days a week do you eat fried food? _____
13. How many times per week do you eat at the following?
_____ Fast food _____ car
_____ restaurant _____ airport
14. Have you been on a special diet recently and if so, which one? _____
15. Have you ever kept a food log?
 Yes No
16. Do you have any medical limitations to your diet?
 Yes No
If yes, what are they? _____
17. Do you have cravings?
 Yes No
18. What type of foods do you crave? _____

19. Do you eat late at night?
 Yes No
20. Do you wake up in the middle of the night and eat?
 Yes No

Section 3- Your Exercise Habits

1. Describe your current exercise habits:

	Freq/wk	Dur/session (in minutes)	Intensity
Cardio			
Resistance Training			
Yoga			

Other Current Daily/Lifestyle Activity (Gardening, housework, yard work): _____

2. How would you describe your fitness condition in terms of your general health and fitness?
 1-10, 10 being fit and 1 being out of shape _____

3. Have you ever done any structured exercise?
 Yes No

If you answered No, please go to question 7. If yes, describe:

	Freq/wk	Dur/session (in minutes)	Intensity
Cardio			
Resistance Training			
Yoga			

4. How long did you stick with it? _____

5. Did you get the results you wanted?
 Yes No

If you answered No, please go to question 7. If yes,

6. Why did you stop? _____

7. What sports or activities do you enjoy or have you participated in and might enjoy doing again?

8. What would you identify as the main barriers preventing you from exercising in the future?

- Procrastination Lack of motivation
- No time Lack of facilities
- Injury Lack of ability/fitness
- Financial cost Lack of relevant knowledge
- Family responsibilities Medical advice

Section 4- Your Stress and relaxation

1. Rank the stress you experience in a typical day on a scale of 1-5, 5 being extremely stressed and 1 being not stressed? _____

2. How many days/week do you feel high levels of stress?
 1-3days 3-5days >5days

3. Does stress sometimes interfere with your health, personal happiness, or ability to be productive at work?
 Yes No

4. Is your job often stressful?
 Yes No

5. If yes, in what way? _____

6. Do you get 7 to 8 hours of sleep on a regular basis?
 Yes No

7. Would you consider the sleep you get quality sleep?
 Yes No

8. What are some ways that you relax/ de-stress?

9. List some factors that stimulate stress for you.

9. Please check one. When you are stressed do you typically:
 Overeat Under Eat Maintain

10. Please check one: When you are stressed do you typically:
 Over-Exercise Under-Exercise Maintain

11. Please check one. When you are stressed do you typically:
 Gain Weight Lose Weight Maintain

12. In the past year, have there been any changes in your family? Please check all that apply
 Marriage Separation Divorce
 Loss of Job Birth Serious
 Illness Death
 Other _____

Declaration:-

I confirm that to the best of my knowledge the information given within this document is correct, and understand that it will be treated with the strictest confidence by Physician's Weight Control and Wellness Centers for services that I may wish to engage in now and in the future.

Signature : _____ Date : _____