



## Weight Loss Questionnaire

Your responses to the following questions will enable your therapist to construct and effective program to help you to lose the weight that you want. All information is private and confidential.

How much (approximately) do you weigh? .....

What is your goal weight? .....

When in your life were you your ideal weight?.....

What changed in your life when you began to gain weight?

.....

.....

.....

...

What emotions do you associate with this period in your life? i.e. guilt, comfort, punishment, contentment, etc.

.....

**On an average day, what do you eat and how much?**

- a) For breakfast.....
- b) Mid-morning .....
- c) Lunch .....
- d) Mid-afternoon .....
- e) Evening meal .....
- f) Supper .....
- g) Other .....

Do you snack between meals? If so, which, and what do you snack on?

.....

.....

.

Do you ever get up during the night for something to eat .....

If you overeat, which of the above foods would you like to cut down on, or cut out altogether?

.....

.....

Approximately how many drinks do you have a day? .....

Do you drink fizzy or sweetened drinks? If so, how many? .....

Do you drink alcohol? If so, how many units per day.....per week? .....

Do you drink water? If so, how many glasses approximately per day?

.....

Who does the food shopping in your household? .....

Who prepares and cooks the food? .....

Do you often leave food on your plate? .....

Do you finish off other people's food? .....

**Do you enjoy: (please check where appropriate)**

Sweet foods? .....

Savoury foods? .....

Fresh fruit? .....

Fresh vegetables? .....

Starchy foods? .....

Fatty foods? .....

**What suggestions do you feel would be most effective for helping you to achieve your goal weight? (please tick)**

Stop overeating

Stop snacking between meals

Stop drinking alcohol

Stop drinking sweet drinks

Stop eating junk foods

Take more exercise

Have more energy

Other .....

Are, or were, either of your parents, brothers or sisters overweight? If so, please say which.

.....

Do you remember any instances of being 'forced' to eat up when you were younger?  
YES / NO

Was food ever used as a reward for doing something good? YES / NO

Did you ever eat to forget about something else? YES / NO

Did you often feel hungry as a child? YES / NO

Do you ever eat when you are not hungry? YES / NO

If yes, please give an example

.....

.....  
Do you ever eat to please someone else? YES / NO

If yes, please give an example  
.....  
.....

Are you constantly thinking about the next meal? YES / NO

Do you have any problematic relationships in your life at present YES / NO

If yes, please state with whom .....

If you answered yes, how do you see this relationship improving .....

How many hours sleep (approximately) do you have per night? .....

**Exercise**

Do you lead an active life? YES / NO

Does your job involve sitting down a lot? YES / NO

Are you involved in any sport or regular exercise YES / NO

If the answer to the above question is no, can you identify a sport that you would enjoy doing? YES / NO

If yes, please say what this would be .....

When would a convenient time for you to do this, be? .....

## **Medication**

Are you currently taking any drugs or prescribed medication? YES / NO

If yes, are you aware of any side effects from these that could cause weight gain YES / NO

If yes, are you willing to consult with your GP to find a more suitable alternative YES / NO.