

MY PERSONAL WEIGHT JOURNEY

Take a moment to answer the following questions about your weight, motivations, and challenges to help guide conversations with your health care professional about a weight-management plan that fits your lifestyle.

PERSONAL INFORMATION

Weight: _____ (lbs)

Height: _____ (ft/in)

What do you feel your weight may be holding you back from doing?

? Approximately how much weight would you like to lose to help you reach your goals? _____ (lbs)

WEIGHT-RELATED CONDITIONS

Select which of the following conditions or diseases you have. **Write in** any prescription or over-the-counter products you are currently taking.

Condition or Disease (select)*	Prescription or Over-the-Counter Products (write in)
<input type="checkbox"/> Sleep disorders (eg, sleep apnea, insomnia)	
<input type="checkbox"/> Chronic pain conditions (eg, arthritis)	
<input type="checkbox"/> Cardiovascular disease	
<input type="checkbox"/> Respiratory disease	
<input type="checkbox"/> Gastrointestinal disorders (eg, liver problems)	
<input type="checkbox"/> Endocrine disorders (eg, hormone)	
<input type="checkbox"/> Diabetes or prediabetes	
<input type="checkbox"/> Depression	
<input type="checkbox"/> Other:	

*This is not a complete list of all possible weight-related conditions.

LIFE MILESTONES/EVENTS & WEIGHT

In the space provided, share any life events that relate to your weight loss or weight gain. Add any specifics you would like. *Possible life events may include: Special occasions/events (eg, wedding, baby, class reunion, vacation), Home or work changes (eg, job change, divorce, personal loss, move), Health or medical changes (eg, nutritionist, injury, surgery, medication)*

When did this occur? (age)	Event	How much weight did you lose/gain?	Weight Loss	
			What did you do to lose weight?	Would you do it again? (Y/N)
_____ years old		Lost _____ (lbs) / Gained _____ (lbs)		
_____ years old		Lost _____ (lbs) / Gained _____ (lbs)		
_____ years old		Lost _____ (lbs) / Gained _____ (lbs)		



WEIGHT-LOSS/MANAGEMENT EFFORTS

How would you describe your efforts to lose or maintain weight? Please select all that apply.

Current efforts	Tried it in the past	Doing it now
Physical activity	<input type="checkbox"/>	<input type="checkbox"/>
Healthy eating	<input type="checkbox"/>	<input type="checkbox"/>
Over-the-counter products	<input type="checkbox"/>	<input type="checkbox"/>
Prescription medication	<input type="checkbox"/>	<input type="checkbox"/>
Commercial weight-loss programs (eg, Weight Watchers®)	<input type="checkbox"/>	<input type="checkbox"/>
Bariatric surgery	<input type="checkbox"/>	<input type="checkbox"/>

How long have you been trying to lose weight?

Less than 2 years
 2-4 years
 5-9 years
 As long as I can remember

CURRENT EATING & ACTIVITY ROUTINES

How would you describe your eating habits? Please select all that apply.

- Eat 3 meals a day
 Frequent snacker
 Binge eater
 Constant dieter
 Eat more than 3 meals a day
 Healthy eater
 Emotional eater
 Other _____

What approaches to healthy eating have you tried in the past? **Circle** what worked for you and **mark an X over** what didn't work.

- Limiting my portion size (eg, using a smaller plate)
 Using meal replacements
 Tracking activity and calories
 Cooking meals at home
 Avoiding sugary foods and drinks
 Reading food labels
 Other _____

Approximately, how many minutes total per week do you spend doing physical activities such as going for a walk, cleaning the house, climbing stairs, light yard work, or biking?

60 min or less (1 hour)
 60-120 min (1-2 hours)
 120-180 min (2-3 hours)
 more than 180 min (3 hours)

Any other weight-related information your health care professional should know?
