Weigh To Go Form

Date

Name (Last, First, MI) Date of Birth

Current height: _____ Current weight: _____ Weight one (1) year ago: _____

What has been your highest non-pregnant weight? _____ Age _____

What has been your lowest adult weight? _____ Age _____

What has been your average weight as an adult? _____

Describe any significant weight changes (gain or loss) that you have had in the last five years:

_____

What is your 12-week weight goal? _____ What is your long term weight goal? _____

DIET HISTORY

What diets/programs have you tried in the past? _____

What diets/programs have worked best for you? _____

Why? _____

NUTRITION

Are you allergic to any foods? Please explain.

Do you have any food intolerances/sensitivities? Please explain.

Are there certain foods that you avoid from your diet? Please explain.

Have you ever been told by a doctor to follow a specific nutrition plan *(i.e. weight loss, diabetic, low cholesterol, etc.)*?

○ Yes ○ No

Are you currently following a nutrition plan *(i.e. diabetic, gluten free, low lactose, low cholesterol, etc.)*?

○ Yes ○ No

If yes, please describe _____

Name (Last, First, MI)_____

PHYSICAL ACTIVITY

How physically active is your daily routine? ○ Light ○ Moderate ○ Heavy ○ Not Active

Do you have any kind of physical limitations? ○ Yes ○ No

If yes, please describe: _____

In the last three (3) months, how many times per week have you participated in physical activity resulting in an elevated heart rate for **at least 30 continuous minutes**, such as jogging, swimming, rapid walking, biking, stair stepping, dancing, etc.?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7

☐ I have a physical disability that prevents me from exercising

If you participate in physical activity, please list type(s) and duration of activity.

What are some of challenges/obstacles that you have encountered in the past?

- ☐ Chewing/swallowing
- ☐ Difficulty with cooking
- ☐ Difficulty with shopping
- ☐ Eating too fast
- ☐ Eating too much *(portions are too large)*
- ☐ Eating when not hungry
- ☐ Emotional eating *(stress, upset, happy, etc.)*
- ☐ Feeling overly hungry
- ☐ Financial challenges
- ☐ Food cravings
- ☐ Lack of appetite
- ☐ Lack of motivation
- ☐ Lack of physical activity *(not seeing results)*
- ☐ Limiting high sugar beverages
- ☐ Limiting sweets/desserts
- ☐ Problems with goal setting
- ☐ Skipping meals
- ☐ Unsure about what to eat

What changes are you ready to make within the next 30-60 days to improve your overall health?

For Office Use ONLY:

Date: _____ Height: _____ Weight: _____

BMI: _____ % of Body Fat: _____ Waist Circumference: _____

BMR: _____ PA Level: _____ Est. Calorie Needs: _____

12 Week Weight Goal: _____ Long-term Weight Goal: _____

*Name (Last, First, MI)*_____

Food and Beverage Record

Please write down everything that you eat and drink for three (3) consecutive days. Please include as much information as possible as this helps us in the evaluation and planning of your nutritional plan.

Date/Time	Location of meal	Food/Beverage Item	Quantity	How Hungry	Comments