DMA Weight & Wellness

What you do feel your weight may be holding you back from, and how will your life be different if you lose weight? What are some changes in your health you would like to see? Star the most important.

At what age do you first remember having issues with your weight? _____

Approximately how much weight would you like to lose? _____

Weight related conditions: Circle any that apply to you.

Sleep disorders: sleep apnea, insomnia	Skin disorders: including frequent infections
Chronic pain conditions: ex. Arthritis	Auto-immune conditions
Cardiovascular disease	Cancers (past or present)
Respiratory disease	Migraines
Gastrointestinal disorders (liver problems, IBU, crohn's, colitis)	Fertility problems
Endocrine disorders (hormones)	Prostate enlargement
Diabetes or pre-diabetes	Other:
Depression	

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

___ 60 mins or less ___ 60-120 mins ___ 120-180 mins ___ > 180 min

Type of activity: _____

Describe your current eating pattern: 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	___ Yo Yo Dieter
__ Eat Meat ___ times daily	___ Eat Vegetables ____ times daily		
__ Eat Fruit ____ times daily	___ Drink soda, juice, sweetened coffee		

Provide a basic snapshot of a typical day of eating looks like: Breakfast, lunch, dinner, snacks, treats and beverages. Please include the general time these are consumed.

Are there any foods that you will not eat or that are off the table?

What are your favorite foods?

Who lives in the home with you? Will they be supportive of your lifestyle changes?

_____

_____

Who does the grocery shopping and cooking for the home?

_____

What do you see as the biggest challenge or obstacles to your weight loss journey?

_____

_____

_____

Describe any patterns you seem to fall into when making health and lifestyle transformations, and your beliefs about your ability to transform your health?

_____

_____

_____

On a scale of 1 to 10, how would you rate your stress level? _____
How do you respond or cope with Stress?

_____

_____

_____

_____

Sleep Quality: Rate on a scale of 0-10, with 0 being horrible, 10 excellent _____/10

On average how may hours of sleep do you get? _____

What time do you typically go to bed & wake up? _____

Work Life:
What do you do for work? What is your work schedule?

_____

Do you usually enjoy your work? YES or NO

How many hours a day do you work? _____