Essential Balance
Holistic Wellness Center

CLIENT WEIGHT LOSS QUESTIONAIRE

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

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

What emotions do you associate with this period in your life? (i.e. happiness, sadness, fear, guilt, shame, comfort, punishment, contentment, etc.)

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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? YES / NO If so, between which meals and what do you snack on?
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Do you ever get up during the night for something to eat? YES / NO If so, what do you eat?

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What foods do you enjoy: (please check where appropriate)

Sweet foods? …….

Savory foods? …….

Fresh fruit? …….

Fresh vegetables? …….

Starchy foods? …….

Fatty foods? …….

Candies? …….

Junk food? …….

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

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

Do you drink fizzy (carbonated) and/or sweetened drinks? YES / NO If so, how many? .....

Do you drink alcohol? YES / NO If so, how many units per day ..... per week? .....

Do you drink water? YES / NO 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 have “seconds”? YES / NO Thirds? YES / NO More? YES / NO

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

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

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

Stop overeating …….

Stop snacking between meals …….

Stop drinking alcohol …….

Stop drinking sweet drinks …….

Stop eating junk foods …….

Eat healthy/healthier foods …….

Do more exercise …….

Have more energy …….

Other .....

Are (or were) either of your parents, brothers or sisters overweight? YES / NO If so, please say which.

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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

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

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

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

Exercise

Do you lead a physically active life? YES / NO

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

Have you ever worked with a personal trainer? YES / NO Now? YES / NO

Are you involved in any sport or regular exercise? YES / NO If no, can you identify a sport or physical activity that you would enjoy doing (i.e. walking, swimming, rock climbing, etc)?.....
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……

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

Medical/Medication

Are you currently under the care of a Practitioner of the Healing Arts (PHA) (i.e. Medical Doctor, Psychologist, Chiropractor, etc)? YES / NO

Are you now, or have you ever been, under the care of a PHA in relation to your weight? YES / NO

If yes, please explain …….

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

If yes, please list medications……
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