Physicians WEIGHT LOSS Centers®

Client Information Questionnaire

Full Name_____Age_____

Email_____ Date_____

1. How did you hear about Physicians WEIGHT LOSS Centers?
   □Newspaper □Friend □Facebook □Doctor □Radio □Other_____
2. What was your weight when you felt your best? _____ Your age then? _____
3. What was your heaviest weight? _____ How long did it take to gain this weight? _____
4. What is your current weight? _____
5. What is your desired weight? _____ What is your desired clothing size? _____
6. What, if anything, have you previously done to lose weight?
   □Exercise □Pills □Fasting □Diet If diet, where? _____
7. How much weight did you lose? _____ Have you gained weight since then? □Yes □No
8. What describes you best? I eat too much: □when nervous □for pleasure
   □when upset □Other_____
9. List what you normally have for:

Breakfast	Mid-Afternoon	Snacks
Midmorning	Dinner	Beverages
Lunch	Evening	Desserts

10. A typical day's food intake for me includes _____calories.
11. Do you feel like you over eat on a daily basis? □Yes □No
12. Where do you normally eat? □Kitchen □Dining Room □Living Room
    □Bedroom □Other_____
13. Do you like to cook and/or prepare your meals? □Yes □No
14. Does anyone encourage you to diet (i.e. doctor, family, friends)? _____
15. Why is it important for you to lose weight? □Appearance □Doctor's Suggestion
    □Tight Clothes □Upcoming Event □Health □Self Esteem □Other_____
    Comments:_____
    _____
    _____