Health Questionnaire

Goals

What is your present weight? _____
What is your ideal weight? _____
When do you plan to meet your goal? (month/ year) _____

Lifestyle & Activity

Do you have any of the following? Please circle all that apply:

High cholesterol snores sleeping problems Sleep Apnea asthma high blood pressure IBS Rheumatoid Arthritis dizzy spells hypoglycemia diabetes breathing problems depression Heart Attack Pace Maker thyroid problems Menopause CPAP machine heart problems alcoholism Celiac Disease vitamin deficiency

What type of work do you do? _____
Do you smoke? _____ If yes, how often? _____
Do you drink alcohol? ___If yes, how often?_____
Are there other individuals in your immediate family (parents, siblings) that are obese? _____
Do you have any physical disabilities? If yes, what?? _____
How often do you exercise (circle one)? Rarely 1-2 days per week 3-5 days per week 6-7 days per week
How long is your exercise per session? (circle one) None <30 min 30-60 min 1 hr >1hr
What Type of exercise do you do? (circle all that apply) Walk Jog Weight Training Bicycling Swimming _____Other
How would you describe your general stress level? (circle one) High Stress Moderate Low Stress
How many hours of sleep do you get per night? (circle one) <4 hours 4-5 hours 6-8 hours >8 hours
How do you feel mostly throughout the day? (circle one) Tired & Fatigued or Energized & Alert

Weight History

What is your age? _____
What was your highest weight in the past 3 years? _____
What was your lowest weight in the past 3 years? _____

Have you done any other diet or program? Yes / No if yes, please fill out :

Diet or Program	How long on diet or program?	Long term success? Yes / No ?	Are you still on the diet or program? Yes / No ?
Weight Watchers			
Jenny Craig			
Keto/ Adkins Diet			
Paleo Diet			
Ideal Protein Diet			
Other _____			

What do you see as your reason(s) for being overweight or overeating?

0 – Type of food 0 – Portions 0 – Alcohol 0 – Snacks 0 – Eating out 0 – Habits 0 – Traveling 0 - Socializing	0 - Watching TV or movies 0 - Depression 0 – Anger 0 – Boredom 0 – Nervousness 0 – Stress 0 – Quit smoking 0 – Enjoy food	0 – Comfort 0 – Job 0 – Fatty foods 0 – Sugar / sweets 0 – Soft drinks 0 - Desserts 0 – Convenience 0 – Lack of time	0 – Unplanned meals 0 – No support 0 – Conflicts 0 – Inconsistent meal times Others _____ _____

Prescriptions

Are you taking any prescriptions? If yes, what? _____
_____

Dietary / Nutritional History

Select the statement that best describes you (check one)

___ TYPE 1 I can eat anything I want and not gain weight.

___ TYPE 2 I can lose or gain weight by adjusting my activity level and eating habits.

___ TYPE 3 I find it very hard to lose weight. I gain weight very easily and have to watch everything I eat.

Do you have any food allergies? Yes / No if yes, what?_____

Are you a vegetarian or vegan? _____

Approximately how many full meals do you eat a day? _____

How often do you snack between meals each day?(circle one) none 1-2 times >3 times

Do you drink coffee or tea? _____ If yes, how many cups a day? _____ and what do you put in it?_____

Do you drink soda regularly? _____ If yes, how many cans/cups a day? _____

How would you describe your typical eating habits: (check one)

____ I eat a very healthy and balanced diet, consisting mostly of fresh fruit and vegetables, lean meats and plenty of water. I rarely eat "junk food" or fast food.

____ I eat a moderately healthy diet, but on occasion eat unhealthy foods . I eat fast food more than 3 times a week. I drink sodas sometimes.

____ I eat a mostly poor and unhealthy diet. I eat junk food almost every day and fast food more than 4 times a week. I drink sodas often instead of water.

Check all that apply:

___Do you often have cravings for sugary or other types of foods throughout the day?

___Are you currently struggling with weight loss?

___Do you lack protein in your diet from meats, legumes, and/or other sources?

___Do you struggle with eating healthy and regularly throughout the day?

How many times each day do you eat the following foods?

Starches (bread, bagel, roll, cereal, pasta, noodles, rice, potato) (circle one) Never 1-2 3-5 6-8 9-11

Fruits (circle one) Never 1-2 3-5 6-8 9-11

Vegetables (circle one) Never 1-2 3-5 6-8 9-11

Dairy (milk, yogurt) (circle one) Never 1-2 3-5 6-8 9-11

Meat, fish, poultry, eggs, cheese (circle one) Never 1-2 3-5 6-8 9-11

Fats(butter, margarine, mayo, oil, salad dressing, sour cream, cream cheese) (circle one) Never 1-2 3-5 6-8 9-11

Sweets (candy, cake, regular soda, juice) (circle one) Never 1-2 3-5 6-8 9-11

What time of the day are you usually the most hungry? (circle one) Morning Afternoon Evening Late Night

What meal of the day is the largest? (circle one) Breakfast Lunch Dinner

Do you have food cravings often? If so, what type? (circle all that apply) Sweets Salty Carbs

Does your doctor know you are joining this program? Yes / No If yes, Name of Doctor_____

How did you hear about Just Results? _____

Your Name:_____

Email:_____

Cell Number:_____

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THIS PROGRAM IS NOT A DIET