



the center for medical weight loss®

WEIGHT CONTROL EXPECTATIONS QUESTIONNAIRE

This form has been designed to assist you in organizing your thoughts regarding exactly what it is you want for yourself and the importance of clearly delineating your expectations when participating in any kind of weight control program. By first filling out this questionnaire as completely as possible, and then reviewing it with your health provider, you will learn what can reasonably be expected to occur.

Name: _____ **Date:** _____

Email Address*: _____

* I understand that I may receive email communication from The Center for Medical Weight Loss from time to time related to my weight loss program. I also understand that I may elect to stop receiving such emails at any time by using the "unsubscribe" link located at the bottom of the email communication

What is your goal weight? _____

Do you have any other expectations (health wise) regarding your weight loss plans?

Describe your home situation: Single _____ Married, no kids _____ Married and kids _____

If you have children at home, what are their ages? _____

If you are married and/or have children, are they overweight _____

How many hours of sleep do you get a night? _____

Do you feel rested when you awaken? _____

How many days per week do you eat breakfast? 1-3 _____ 4-7 _____ never _____

Who cooks dinner in your home? _____

Describe your favorite meal. _____

Who does the grocery shopping in your home? _____

How much water do you drink per day? _____

How many times have you exercised in the past week? _____

If you have exercised, what is the average length of time (hours and minutes) you exercised? _____

Do you have any health issues that limit exercise? Yes _____ No _____

If yes, please explain. _____



the center for **medical weight loss**®

How many hours of television do you watch per day? _____

If you have tried previous weight loss programs, what did you like about the program?

What did you not like?

If you have tried to lose weight before, what do you think limited your success?

Which of the following statements describes you best (circle one):

1. I am highly motivated to lose weight and will do whatever it takes to get healthy.
2. I definitely want to lose weight but I would rather go slow and steady.
3. I know weight loss is hard and I am not sure any program will work for me.

Which of the following statements describes you best (circle one):

1. I know exercise is **necessary** to lose and maintain weight loss, but there is no way I can fit it into my schedule.
2. I already exercise as much as I possibly can which is 1-3 times per week.
3. I currently exercise most days for more than 30 minutes.