



TRANSFORMATIONS
PHYSICIANS WEIGHT MANAGEMENT

Lifestyle, Nutrition, & Fitness Questionnaire

BODY TYPE

EATING PATTERNS

SELECT THE STATEMENT THAT BEST DESCRIBES YOU

- TYPE I** I can eat anything I want and not gain weight. I have a very hard time gaining weight.
- TYPE II** I can lose or gain weight by adjusting my activity level and eating habits
- TYPE III** I find it very hard to lose weight. I gain weight very easily and have to watch everything I eat.

ACCURATELY RATE YOUR PROFESSIONAL ACTIVITY LEVEL

- SEDENTARY** A person who works in an office and sits most of the day.
- MODERATELY ACTIVE** A housewife, teacher, grocery clerk, or an auto mechanic
- ACTIVE** A person who works in a profession that requires physical activity, such as a carpenter
- VERY ACTIVE** If you provide any type of full time manual labor, such as a landscaper

PLEASE CHECK THE APPROPRIATE BOXES THAT MOST CLOSELY DESCRIBE YOUR EATING PATTERNS

Do you follow a special diet? No If yes, which one

Diabetic Low Sodium Low Fat Low Cholesterol
 Kosher Vegetarian Vegan Wheat Free
 Low Carb (South Beach) No Carb (Atkins)
 Other _____

Which meals do you regularly eat?

Breakfast Lunch Brunch Dinner

Do you eat out or order food in? Yes No

If yes, how often?

Daily Weekly
 Monthly

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

Starches (bread, bagel, rolls, cereal, pasta, noodles, rice, potatoes)

Never Less than 1 1-2 3-5 6-8 9-11

Fruits

Never Less than 1 1-2 3-5 6-8 9-11

Vegetables

Never Less than 1 1-2 3-5 6-8 9-11

Meat, Fish, Poultry, Eggs, Cheese

Never Less than 1 1-2 3-5 6-8 9-11

Fats (butter, margarine, mayonaise, oil, salad dressing, sour cream, cream cheese)

Never Less than 1 1-2 3-5 6-8 9-11

Sweets (candy, cake, regular soda, juice)

Never Less than 1 1-2 3-5 6-8 9-11

CUSTOMIZED SUPPLEMENT REPORT

PLACE A CHECK MARK NEXT TO THE QUESTION THAT APPLIES TO YOU

Are you pregnant or planning pregnancy?

Do you eat fast foods? Yes No

Do you work long or hard hours? Yes No

Do you feel overwhelmed, exhausted, fatigued or malaise?

Do you use coffee, teas, sodas, alcohol, or cigarettes?

Do you ever experience gas, bloating, flatulence, acid indigestion, constipation, loose stools, or irregularity?

Do you experience insomnia, snoring, chest pain, or shortness of breath

Do you ever experience food sensitivities or allergies? Yes No

Do you have a history of a pinched nerve, slipped or herniated discs, arthritis, or back pain?

Do you ever experience popping, crackling, or stiffness in your joints?

Do you have any type of arthritis, swelling, redness, or discomforts of any of your joints?

Do you ever experience muscle cramps (sports or menstrual), anxiety nervousness or depression?

Do you have weak or thin nails, hair, or skin?

Do you bruise easily Yes No

Do you experience hair loss Yes No

Do you ever experience low energy, or loss of vitality?

Do you have a history of colds, flus, infections, or a poor immune system?

Are you taking medication for high cholesterol? Yes No

Do you experience tooth decay, poor gum health or gingivitis?

Do you often have cravings for sugary or other types of foods throughout the day? Yes No

Do you struggle with eating healthfully and regularly throughout the day? Yes No

What do you feel have been your obstacles to weight loss?

What diets have worked for you in the past?

Do you feel that your weight/health prevents you from pursuing your goals as far as your:

Family? Career? Other? Explain

Do you like to cook?

What grocery store do you use most frequently

What hobbies do you currently have or would like to pursue?

What beverages do you drink daily and how much? _____ times or glasses per day Types of beverages, please list (e.g. water, juice, tea, coffee, soda, alcohol) _____ _____	Do you have any food allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes please list. _____ _____
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Are you actively working out in a gym or at home? Yes No

Do you like to exercise? _____

What types of exercise do you like? _____

What types of exercise do you NOT like? _____

What types of exercise do you want to learn? _____

