Worksheet for Weight Loss

Complete this worksheet to gauge where you might want to make simple changes in your life to get to or maintain a healthy weight. Share this with your doctor or other healthcare professional for additional insight or support.

What concerns you about your weight?

Why is now a good time for you to lose weight?

What do you expect will change at a lower body weight?

What steps are you currently taking to manage your weight?

On a scale of 0-5, (0 = not willing, 5 = very willing) how willing are you to change your diet to lose weight?
0 1 2 3 4 5

On a scale of 0-5, (0 = not willing, 5 = very willing) how willing are you to increase your physical activity?
0 1 2 3 4 5

Medical:
List any medical conditions that make weight loss difficult for you:

Weight History:
Previous attempts at weight loss: (check all that apply)
_____Low calorie, low carb, low fat
_____Exercise
_____Commercial self-select plan (Weight Watchers, Healthy Weigh, other)
_____Meal replacement program (Nutrisystem, Jenny Craig, HMR, Slim Fast, other)
_____Supervised weight loss (physician, dietitian, other)
_____Weight loss surgery, _____ year of surgery _____ type of surgery
_____Weight loss medications (prescribed, over the counter) List: _____
_____Other: List _____

What do you think are the causes of your excess weight?

Social:
Who supports your effort to lose weight?
How do they support you?

Who makes weight loss harder for you?

Lifestyle:
How do you spend your time during the day?

Estimate how many hours per day to you spend sitting?
How many hours per day are spent in front of a screen (TV, computer, e-reader)?
How many hours do you usually sleep?
How would you describe your sleep quality? ___ Good ___ Poor

Do you smoke? ___ yes ___ no
Are you interested in resources to quit smoking? ____ yes ____ no

Diet:
Are you currently following a special diet?
__ Diabetic __ Low fat/heart healthy
__ Low sodium __ Gluten-free
__ Vegetarian __ Other (please list)

List all supplements you take:

List all food allergies or intolerances:

Who does the grocery shopping?
Who cooks meals?
Who do you coordinate meals with?
How frequently do you eat meals outside the home? _____ times per week
(Example: fast food, restaurant, take-out, cafeteria)

Food Frequency:
How many meals do you eat per day? ____ 1-2 ___ 2-3 ___ 4-5 ___ 6-7 ____ 8+
How many snacks do you eat per day? ____ 1-2 ___ 2-3 ___ 4-5 ___ 6-7 ____ 8+
Which is your largest meal? __ breakfast __lunch __dinner __ snacks

How many 1 cup servings of vegetables do you eat per **day** ___ 0-1 ___ 2-3 ___ 4-5 ___6+
How many 1 cup or 1-piece servings of fruit do you eat per **day** ___ 0-1 ___ 2-3 ___ 4-5 ___6+
How many 1 cup servings of dairy to you eat per **day** ___ 0-1 ___ 2-3 ___ 4-5 ___6+
How many times per **day** do you eat whole grains ___ 0-1 ___ 2-3 ___ 4-5 ___6+
How many times per **week** do you eat red meat ___ 0-1 ___ 2-3 ___ 4-5 ___6+
How many times per **week** do you eat sweets ___ 0-1 ___ 2-3 ___ 4-5 ___6+
How many times per **week** do you eat snack foods ___ 0-1 ___ 2-3 ___ 4-5 ___6+

Usual beverages: (check all that apply)
___ water ___soda
___ diet beverages ___ juice / sweetened beverages
___ coffee ___ milk
___ tea ___ other
___ energy drinks
Alcohol consumption: ____ drinks per day / week / month / year
I usually eat/drink too much _____
I don't eat/ drink enough _____

Physical Activity

Physical activity is defined as moving your body through space. This includes lifestyle activity. *Exercise* is planned activity that is in addition to your usual daily activities of living.

In what ways are you physically active? (check all that apply)

___ shopping
___ housekeeping
___ gardening / yard work
___ pet walking
___ other (please list)

What types of exercise do you do? (check all that apply)

___ walk
___ cycle
___ elliptical / other cardio
___ physical therapy exercises
___ weights or resistance exercise
___ chair exercise
___ fitness classes or videos
___ yoga / tai chi / stretching
___ swimming or pool exercise

How frequently do you exercise? _____ hours _____ minutes per week

How would you rate the level of intensity of your exercise?

0	1	2	3	4	5	6	7	8	9	10
Nothing		Very light		Light		Moderate		Hard		Very hard

What prevents you from exercising?

___ pain
___ time
___ disliking it
___ not motivated
___ fatigue
___ not sure how to exercise
___ other:
_____
_____

Goal Setting

What is one dietary change you would be willing to make to promote weight loss?

What is one physical activity improvement you would be willing to make?