

# FAST TRACK

METABOLIC WEIGHT LOSS CENTER

What type of program are you considering?

Gastric Band   Gastric Bypass   Sleeve   Nonsurgical [i.e. Fast Track, Adipex])   Undecided

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## 1. WEIGHT HISTORY:

When did you first start to have a problem with weight? \_\_\_\_\_

Why did you start to worry about your weight? \_\_\_\_\_

Why do you think you have a weight problem? \_\_\_\_\_

Which members of your family are overweight? \_\_\_\_\_

What was your lowest adult body weight? Age \_\_\_\_\_ Weight \_\_\_\_\_ Year \_\_\_\_\_

What was your heaviest adult body weight? Age \_\_\_\_\_ Weight \_\_\_\_\_ Year \_\_\_\_\_

What was your most weight loss on any type of program? \_\_\_\_\_ pounds   Year: \_\_\_\_\_

How was it achieved (ie. Exercise, Atkins, etc.?) \_\_\_\_\_

What do you consider a good weight for yourself? \_\_\_\_\_ pounds.

On previous diet attempts, which you achieved wt loss, why do you feel you regained wt?  
(ie. hunger, boredom, etc.) \_\_\_\_\_

What do you feel are your barriers to keeping your weight off?

- Lack of motivation
- Lack of knowledge about nutrition
- No support (family or friends)
- Time issues
- Cost
- Physical hunger
- Others \_\_\_\_\_
- Emotional eating
- Frustration with lack of results

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## 2. DIETARY HISTORY:

How many meals do you usually have per day? \_\_\_\_\_

Do you frequently skip meals? \_\_\_\_\_ Yes \_\_\_\_\_ No

If you answered Yes, which meal(s) do you skip most frequently? And why? \_\_\_\_\_

Who plans the meals? \_\_\_\_\_

Who cooks? \_\_\_\_\_ And food shopping? \_\_\_\_\_

How many times do you eat out per week? \_\_\_\_\_

Which meal(s) do you eat out most frequently? \_\_\_ Breakfast \_\_\_ Lunch \_\_\_ Dinner  
How often do you snack between meals? \_\_\_ 0 to 1 \_\_\_ 2 to 4 \_\_\_ 5 to 7 Other \_\_\_\_\_

What do you snack on? \_\_\_\_\_  
\_\_\_\_\_

List your food cravings (candies, chocolate, fried foods, ice cream, starches, sweets, etc.)

Do you drink during your meal? \_\_\_ Yes \_\_\_ No

Do you drink alcoholic beverages? \_\_\_ Yes \_\_\_ No

How many alcoholic beverages per week? \_\_\_\_\_

What types of alcoholic beverages? \_\_\_\_\_

Do you smoke? \_\_\_ Yes \_\_\_ No If Yes, how many packs per day? \_\_\_\_\_

Do you drink caffeinated coffee? \_\_\_ Yes \_\_\_ No How many cups per day? \_\_\_\_\_

Do you drink caffeinated tea? \_\_\_ Yes \_\_\_ No How many cups a day? \_\_\_\_\_

Do you drink soda? \_\_\_ Yes \_\_\_ No What kind? \_\_\_\_\_ How many times a day? \_\_\_\_\_

Do you take vitamin, mineral or nutritional supplements? \_\_\_ Yes \_\_\_ No

If Yes, please list them. \_\_\_\_\_

Are you participating in any type of special diet or eating plan currently? \_\_\_ Yes \_\_\_ No

If Yes, please list them. How long did you/have you been participating? \_\_\_\_\_

What diets have you tried? (e.g. Weight Watchers, South Beach, Atkins, Low Carb, Low Fat, Calorie Counting)

Diets:	Dates:	Wt Lost:	Wt Regain: Y,N, Y+
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have any of these diets been medically supervised (by a physician)? If Yes, When? And How Long?

\_\_\_\_\_  
\_\_\_\_\_

### 3. DIETARY HABITS:

What triggers you to eat?

\_\_\_ Hunger \_\_\_ Anger \_\_\_ Depression \_\_\_ Loneliness

\_\_\_ Lack of control \_\_\_ Boredom \_\_\_ Family gatherings \_\_\_ Social situations

How often do you overeat or binge at meals/snacks? \_\_\_\_\_

Do you ever feel compulsive about foods? \_\_\_ Yes. \_\_\_ No.

Do you achieve feeling of fullness? \_\_\_ Yes. \_\_\_ No.

### 4. FOOD ALLERGIES/INTOLERANCES

\_\_\_\_\_  
\_\_\_\_\_

**5. FOOD DISLIKES/CULTURAL RESTRICTIONS** \_\_\_\_\_

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**6. EXERCISE:**

Do you have any physical limitations? \_\_\_\_ Yes \_\_\_\_ No.

If Yes, explain \_\_\_\_\_

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Are you currently exercising? \_\_\_\_ Yes \_\_\_\_ No

If so:

Where? \_\_\_\_\_

How Often? \_\_\_\_\_

Type of exercise \_\_\_\_\_

Workout duration? \_\_\_\_\_

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**EMOTIONAL INVENTORY**

It is well known that emotional issues play a major role in the development of weight problems. Sometimes we eat when we are upset, under stress, bored, or for other reasons. Please think carefully when answering these questions about how you feel about food and your weight, and how food makes you feel.

*Answer each question using the following scale:*

- 1- Never/Strongly Disagree
- 2- Rarely/Somewhat Disagree
- 3- Sometimes/Somewhat Agree
- 4- Usually/Mostly Agree
- 5- Always/Strongly Agree

- \_\_\_\_\_ My mood changes when I gain or lose weight
- \_\_\_\_\_ I overeat or binge at mealtimes or on snacks
- \_\_\_\_\_ I am always thinking about food, even when not at mealtimes
- \_\_\_\_\_ I feel full when I am finished eating
- \_\_\_\_\_ My weight interferes with my daily activities
- \_\_\_\_\_ I like to eat in front of the television