Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_ Profession\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| How can I help you? (open-ended question to avoid assumptions that may embarrass client) |  |
| --- | --- |
| Previous experience with diet? |  |
| Roadblocks to success of previous diets as seen by client |  |
| 24hr food recall? Is this your typical eating pattern/habits? | Breakfast:Lunch:Dinner:Snacks:Extra notes: |
| **Food and Drink-related questions** |  |
| Sugar consumption? |  |
| Coffee consumption? |  |
| Other drinks + cups + frequency |  |
| Foods you can’t resist+ your weakness |  |
| Cravings? What? And when? |  |
| Food allergies |  |
| Food likes/dislikes |  |
| Meal preferences: number of meals |  |
| Reasons for success of diet from the client’s point of view |  |
| **Lifestyle Questions** |  |
| Work? Work hours? Desk job? |  |
| Sleeping pattern  |  |
| Physical activity? (Exercise and non-exercise) |  |
| Daily steps  |  |
| **History** |  |
| Medications |  |
| Complaints and Diseases |  |
| Family history of obesity and diseases |  |
| Social Support |  |
| **Client Assessment** |  |
| Why do you want to lose weight? |  |
| Target weight |  |
| Readiness for change  | **1 2 3 4 5 6 7 8 9 10** |