OVERWEIGHT/OBESITY

CHRONIC DISEASE MANAGEMENT FORM

PERSONAL INFORMATION

Full Name :

Date of Birth : D D M M Y Y

E-Mail :

Phone Number : **Gender** : ☐ Male ☐ Female

Weight (lbs) : **Height** :

WEIGHT AND FAMILY HISTORY

Have you been told by a healthcare provider that you are overweight or obese?

☐ Yes **If yes, how long have you been aware of this?**

☐ No **What was your last BMI reading?**

Do you have family members who appear overweight or obese? ☐ Yes ☐ No

DIET AND EXERCISE

Are you currently following a special diet or exercise program for weight management? ☐ Yes ☐ No

Are you satisfied with your current weight, or do you wish to lose or gain weight?

☐ Satisfied ☐ Want to lose weight ☐ Want to gain weight

On a scale of 1-10, how much weight do you want to lose or gain? (1 being the least, 10 the most)

On a scale of 1-10, how ready are you to lose or gain weight? (10 being ready today)

PREVIOUS WEIGHT MANAGEMENT ATTEMPTS

Have you tried any methods in the past to help you lose or gain weight?

☐ Yes **If yes, please specify the methods used (e.g., healthy lifestyle changes, medications, herbs, surgery):**

☐ No

How successful were your previous weight management attempts?

☐ Very successful ☐ Somewhat successful ☐ Not successful

THANK YOU FOR YOUR INFORMATION