Wellness Evaluation Form

Body Composition Questionnaire

Collier County
Administrative Services Division
Risk Management

Circle One: Employee Spouse Child SAP#_____

(Please answer all questions. The information you provide will NOT impact your health insurance.)

Name _____ Date of Birth _____ Age _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Occupation _____

Current Weight _____ Current Height _____ Sex: □ Male □ Female

At what age did you begin to be concerned with your weight? _____

In your **opinion**, what contributes to your weight concerns and weight gain?

□ Portion sizes □ Eating too much fat and sugar □ Stress eating

□ Emotional eating □ Compulsive eating □ Lack of exercise

□ Medications (please list below) □ Lack of knowledge about healthful eating and exercise

Please describe any events you believe are related to your weight gain

_____

Lowest weight as an adult (and when)? _____ **Peak** adult weight (and when)? _____

Other significant weight **gain**? _____ Other significant weight **loss**? _____

Activity growing up: Involved in sports/athletics? □ Yes □ No

Which Sports/Activities? _____

Did your family have dinner together? □ Yes □ No

□ Meat & Potatoes □Pasta □Fried Food □ Fast Food Dessert □ Yes □ No

List other foods and beverages you routinely had growing up and into early adulthood:

How many meals do you currently consume per day? _____

How many snacks do you currently consume per day? _____

What do some of these meals and snacks look like daily, please list:

What types of food or beverages do you find hard to say no to or you have the least amount of control with?

Are there specific times, seasons, or occasions you have more difficulty being mindful about what you eating?

Do you have any food Intolerances, food allergies, food restrictions, special diet? Please list.

Current medications and supplements

Name	Dose	How often	Start Date	Vitamin/Mineral	OTC (Aspirin, etc)	OTC (Herbal)

Please list allergies to medications and your reaction

_____

_____

_____

_____

Current Lifestyle

Please check the appropriate box:

□ Single □ Married □ Divorced □ Widow □ Significant Other

Do you live alone? □ Yes □ No

Do you have children? □ Yes □ No If yes, please list ages _____

Do your children live at home? □ Yes □ No □ N/A

Do you smoke? □ Yes □ No

If yes, number of packs per day _ number of years __When did you quit _____

Do you drink alcohol? ___How many drinks/day ____How often _____

Do you use illicit drugs? □ Yes □ No

If yes, please describe drug, method and frequency of use (e.g. IV, smoke, snort, etc) _____

Do you currently exercise regularly? □ Yes □ No

If yes, what exercise do you perform?_____

How many times per week? _____How long do you exercise each time? _____

Weight Loss History

If treatment was recommended, what have you tried in the past?

□ Lifestyle □ Medication □ Surgery

Lifestyle (Diet and Exercise)

Name of Program	Year Started	How long?	Start Weight	# of lbs lost	Time wt stayed off	# of lbs regained

Weight Loss Medications (Prescription, Over-the-counter, Herbal)

Name of Program	Year Started	How long?	Start Weight	# of lbs lost	Time wt stayed off	# of lbs regained

Have you had nutrition counseling? ☐ Yes ☐ No

If yes, please describe _____

Personal Medical History

□ Heart Disease □ Diabetes □ Sexual Dysfunction □ Kidney Disease

□ High Blood Pressure □ GI Disorder □ Polycystic Ovarian Syndrome □ Bariatric Surgery

□ High Cholesterol □ Gout □ Anemia (Gastric bypass, Lap Band)

□ Sleep Apnea □ Arthritis □ Clotting/Bleeding Disorder

□ Asthma □ Osteoporosis □ Cancer

□ Thyroid Disorder □ Urinary Incontinence □ Other _____

Are you currently on a diet for a medical reason? □ Yes □ No

Have you ever had surgery? □ Yes □ No

Please list ALL **surgical** procedures and the approximate date: _____

_____

_____

Are you receiving any psychiatric/psychological services at this time? □ Yes □ No

If yes, by whom_____

Are you currently being treated for depression? □ Yes □No

If yes, by whom _____

Are you interested in finding out more information about our Emotional Wellness program?

Have you ever been diagnosed with an eating disorder? □Yes □ No

If yes, please describe _____

Binge Eating and Purging (Please check the appropriate box to your response)

Aside from holiday feasts, have you ever eaten a large amount of food rapidly and felt that this eating incident was excessive and out of control afterward? □ Yes □ No

If you answered yes to the above question, how often have you engaged in this behavior during the last year? Please check one.

1. Less than once a month
2. About once a month
3. A few times a month
4. About once a week
5. About three times a week
6. Daily

Have you ever purged (used laxatives, diuretics, or induce vomiting) to control your weight?

□ Yes □ No

If you answered yes to the above question, how often have you engaged in this behavior during the last year? Please check one.

1. Less than once a month
2. About once a month
3. A few times a month
4. About once a week
5. About three times a week
6. Daily

Please feel free to use this space for any additional information.

_____

Readiness

1) What do you feel your weight may be holding you back from doing?

2) Approx. How much weight would you like to lose to help reach your goals?

3) What are your goals about weight control & management?

4) Your level of interest in losing weight

1 2 3 4 5

Not interested Very Interested

5) Are you planning to adopt lifestyle changes as part of your weight control program?

No Yes

1 2 3 4 5

6) How much support does your family provide you to reach your weight loss goals?

No support Much Support

1 2 3 4 5

7) How much support do your friends provide?

No support Much support

1 2 3 4 5

8) What is the hardest part about managing your weight?

9) What do you believe will be the most to help you lose weight?

10) How confident are you that you can lose weight?

Not confident Very Confident

1 2 3 4 5

Please Complete for the Next 6 Days (Include Condiments, Creamers, Added Sugars, etc.)

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6
Breakfast						
Snack						
Lunch						
Snack						
Dinner						
Desserts						
Beverages						