Shrinkyourmindshrinkyourbody.com

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Weight Release Questionnaire

Once you have completed all answers, please Fax to: (310) 858-1188

Name:
Age:

Phone:
E-mail:

1.) Do you currently have a medical condition(s)? (Please mark with an x)

Yes ☐ No ☐

a. If yes, briefly describe:

b. Please list any medications, vitamins/minerals or supplements you take, if any

2.) Have you ever seen a mental health practitioner (i.e. therapist, psychiatrist, etc.)?

Yes ☐ No ☐

a. If yes, please describe what was helpful or not:

3.) Have you ever experienced hypnosis (or guided imagery) before?

Yes ☐ No ☐

a. If yes, when?

b. What was the experience like for you?

4.) Do you have any concerns about experiencing hypnosis?

Yes ☐ No ☐

a. If yes, describe your concerns:

5.) Are you currently in a relationship?

Yes ☐ No ☐

6.) Do you have any children?

Yes ☐ No ☐

a. How many? Ages?

7.) What is your current height and weight?

8.) Do you have an ideal weight?

Yes ☐ No ☐

a. If yes, what is it?

9.) Why do you want to release weight now?

10.) Please check any of the boxes that you feel contribute to your difficulty releasing weight .

☐ I start out well but it gets too difficult to stay motivated.

☐ I eat according to my emotional state (bored, lonely, happy, sad).

☐ I have difficulty tolerating cravings.

☐ I have problems finding the time and energy to get and stay healthy.

☐ Lack of confidence or self-esteem, e.g. "I don't feel worthy or value myself enough to make the effort.

☐ I don't value my accomplishments so I self-sabotage.

☐ I think things like, "I deserve a treat," "It's not fair that others get to eat and stay thin, "or "I've had a rough day/week/year".

☐ I follow childhood patterns like sweets for being good or being deprived of foods to punish.

Other (please describe):

11.) Are there other things in your life you would like to release?

Yes ☐ No ☐

a. If yes, describe:

12.) Have you ever successfully released weight and kept it off?

Yes ☐ No ☐

a. If yes, what did you do (i.e. exercise, eat less, counseling etc.)?

b. For how long did you keep the weight off?

c. What changed that made the weight return?

13.) Have you ever felt fit and healthy?

Yes ☐ No ☐

a. If yes, when?

b. Describe how you looked and felt:

14.) Are there situations or people that trigger unhealthy food choices or overeating?

Yes ☐ No ☐

a. If yes, briefly describe:

15.) What are the foods that trigger overeating or get you off track?

16.) At what point did you initially develop a concern about weight?

17.) How was food dealt with in your family?

18.) How did your parents (or other family members) relate to you regarding your weight?

19.) Do you have any concerns about what your life would be like when you release the weight?

Yes ☐ No ☐

a. If yes, what?

20.) Are there any benefits that you have experienced to having extra weight?

Yes ☐ No ☐

21.) Do you tend to be more motivated by potential reward or fear of negative consequences?

Yes ☐ No ☐

22.) I am a people pleaser and end up of taking care of others.

Always ☐ Very often ☐ Sometimes ☐ Rarely ☐ Never ☐

23.) I have difficulty with people in authority positions.

Always ☐ Very often ☐ Sometimes ☐ Rarely ☐ Never ☐

24.) I tend to challenge authority when upset.

Always ☐ Very often ☐ Sometimes ☐ Rarely ☐ Never ☐

25.) I am very tense and have a lot of stress.

Always ☐ Very often ☐ Sometimes ☐ Rarely ☐ Never ☐

26.) My life feels out of control to me.

Always ☐ Very often ☐ Sometimes ☐ Rarely ☐ Never ☐

27.) Being in control is very important to me.

Always ☐ Very often ☐ Sometimes ☐ Rarely ☐ Never

28.) I usually eat a meal in 20 minutes or less.

Always ☐ Very often ☐ Sometimes ☐ Rarely ☐ Never ☐ ☐

29.) I chew my food slowly.

Always ☐ Very often ☐ Sometimes ☐ Rarely ☐ Never ☐

30.) I feel I can control when and how much I eat?

Always ☐ Very often ☐ Sometimes ☐ Rarely ☐ Never ☐

31.) I have an overwhelming urge to eat until I am stuffed and feeling uncomfortable?

Always ☐ Very often ☐ Sometimes ☐ Rarely ☐ Never ☐

32.) I eat less than 2 hours before going to sleep.

Always ☐ Very often ☐ Sometimes ☐ Rarely ☐ Never ☐

33.) I do other things while eating (i.e use the computer, drive, watch TV.).

Always ☐ Very often ☐ Sometimes ☐ Rarely ☐ Never ☐

34.) At what point do you realize you've had too much to eat?

35.) Are there situations where you find you do not overeat?

Yes ☐ No ☐

a. If yes, describe:

36.) Do you mostly overeat by yourself or with others?

37.) Do you find that that your relationship with food affects your mood (i.e. depression, anxiety, etc.)?

Yes ☐ No ☐

a. If yes, describe:

38.) Are there things in your life that you try to avoid thinking about or taking action on?

Yes ☐ No ☐

a. If yes, what?

39.) Are there members of your family (or close friends) struggling with weight issues?

Yes ☐ No ☐

a. If yes, do you live with them?

Yes ☐ No ☐

40.) Are there any metaphors or images that come to mind when you think about your relationship to food?

Yes ☐ No ☐

a. If yes, what?

41.) Do you have sleep issues?

Yes ☐ No ☐

a. If yes, please put an x next to all that are relevant:

- ☐ Too much sleep.
- ☐ Not enough sleep.
- ☐ I have trouble falling asleep
- ☐ I wake up a lot
- ☐ I wake up too early
- ☐ Other (please describe):

42.) What do you do for fun? Any hobbies?

43.) In general, how would you rate your general level of satisfaction in your life?

Very Dissatisfied ☐ Dissatisfied ☐ A Little Dissatisfied ☐
Satisfied ☐ Very Satisfied ☐

44.) Please indicate your level of stress for each category below:

Finances
None ☐ A little ☐ Moderate ☐ Quite a bit ☐ Severe ☐

Daily Hassles Being Too Busy
None ☐ A little ☐ Moderate ☐ Quite a bit ☐ Severe ☐

Primary relationship
None ☐ A little ☐ Moderate ☐ Quite a bit ☐ Severe ☐

Other family
None ☐ A little ☐ Moderate ☐ Quite a bit ☐ Severe ☐

Friends
None ☐ A little ☐ Moderate ☐ Quite a bit ☐ Severe ☐

Kids
None ☐ A little ☐ Moderate ☐ Quite a bit ☐ Severe ☐

Loneliness
None ☐ A little ☐ Moderate ☐ Quite a bit ☐ Severe ☐

Past traumas
None ☐ A little ☐ Moderate ☐ Quite a bit ☐ Severe ☐

Health
None ☐ A little ☐ Moderate ☐ Quite a bit ☐ Severe ☐

Other
None ☐ A little ☐ Moderate ☐ Quite a bit ☐ Severe ☐

If other, describe:

42.) 45. you have any complaints about any of the following:

☐ Appetite
☐ Bleeding gums

- [ ] Bruising
- [ ] Chewing or swallowing
- [ ] Constipation
- [ ] Diarrhea
- [ ] Edema
- [ ] Indigestion
- [ ] Menstrual difficulties
- [ ] Seeing in dim light
- [ ] Sudden weight change
- [ ] Stress

46. List any food allergies or intolerances.

47. Do you drink alcohol? If so how much?

48. Do you use tobacco in any way?

Yes ☐ No ☐

If yes, please describe.

49. To tailor your counseling experience to your needs, it would be useful to know your expectations. Please check one of the following to indicate the amount of structure you believe meets your needs:

☐ Just tell me exactly what to eat for all my meals and snacks. I want a detailed food plan. Example: 3/4 cup corn flakes, 1 cup skim milk, 6. oz orange juice, 1 slice whole wheat toast, 1 tea spoon jam.

☐ I want a lot of structure but freedom to select foods. I want to use the exchange system. Example: 1 milk, 2 starch, 1 fruit, 1 fat.

☐ I want some structure and freedom to select foods. I want to use a food group plan. Example: 1 serving of dairy, fruits, fat group; 2 servings of grains.

☐ I don't want a diet. I just want to eat better. I will just set food goals each week.

50. Please describe your current level of physical activity:

☐ None – I never exercise

☐ Low – I exercise 1-2 times a week

☐ Moderate – I exercise 2-3 times a week

- [ ] Moderate/High – I exercise 4–5 times a week
- [ ] High – I exercise more than 5 times a week

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