

Inside Out Weight Loss Program

Initial Evaluation Form—Nutrition Wellness

Please Complete this food dairy for the past few 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						

Complete as much as you can

Fill out & Bring to Nutrition Appt

1) Is there a reason you are seeking weight loss program?

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

3) Your level of interest in losing weight

1	2	3	4	5
Not interested			Very Interested	

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

1	2	3	4	5
No			Yes	

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

1	2	3	4	5
No support			Much Support	

6) How much support do your friends provide?

1	2	3	4	5
No support			Much support	

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

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

9) How confident are you that you can lose weight at this time?

1	2	3	4	5
Not confident			Very Confident	