The Aesthetic and Wellness Center, PLC
3825 State Road 64 E Suite 300 Bradenton, FL 34208 941-749-0741

Weight Loss Consumer Bill of Rights

WARNING:

- Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1 ½ pounds to 2 pounds per week or weight loss of more than 1 percent of body weight per week after the second week of participation in a weight loss program.
- Consult your physician before starting any weight-loss program.
- Only permanent lifestyle changes, such as making healthful food choices and increasing physical activity, promote long term weight loss.
- Qualifications of this provider are available upon request.
- You have a right to: ask questions about the potential health risks of this program and its nutritional content, psychological support, and educational components.
- Receive an itemized statement of the actual or estimated price of the weight loss program, including extra products, services, supplements, examinations, and laboratory tests.
- Know the actual or estimated duration of the program.
- Know the name, address and qualifications of the dietitian or nutritionist who has reviewed and approved the weight-loss program according to Section 468-505(1)(j), Florida Statutes.

Required to be posted by Section 501.0575 of Florida Statutes

I have read the above statement:

______________________________ ______________

Patient's Name Printed **Date**

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History and Lifestyle Evaluation

Present Weight:___________

Height: ________________

What is your weight goal?
____

When would you like to reach your goal weight? ____________

Weight at 20 y/o: ______

Weight one year ago: ______

When did you begin to gain weight?
____After childbirth
____After marriage
____After an employment change
____During a stressful time
____Since childhood
____Other(explain)_______________

How long have you been overweight?
____1 year or less
____2 to 5 years
____6 to 10 years
____>10 years

What do you feel is the reason for your weight problem?
____Frequent overeating
____Fattening foods
____Lack of exercise
____Heredity
____Other (explain)
____

How many meals do you eat each day?
____

How many serious attempts have you made at dieting? _______________

How long have you been able to stick to a diet?
____0 to 1 month
____2 to 6 months
____7 to 12 months
____Over 12 months

What other weight reduction methods have you tried?
____Weight Watchers
____Other diet centers
____Diet book
____Physician
____Do it yourself
____Diet products _______________

Why did you drop out of diets before?
____Boredom
____Hunger
____Stress
____Needed assistance
____Other
____

What is the nature of your difficulties while dieting?
____
____

Have you been advised by your physician to lose weight?
____Yes ____No

Do you have any physical problems that you know are associated with your weight?
____
____

Why do you want to lose weight?
____Social reasons
____Appearance
____Health reasons
____To please family/friends
____Special occasion (list)
____
____Other (explain)
____

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Has your husband/wife encouraged

you to lose weight? __Yes __No
Explain __________________

From a scale of 1 to 10, (10 the highest)
How motivated are you to lose weight?

_____
Less than 8, explain
____

Do you work outside the home?
____No
____Part-time
____Full-time
Occupation __________________

Age:
____Under 18
____18 to 24
____25 to 34
____35 to 49
____50 to 64
____Over 64

Marital Status:
____Married
____Divorced
____Single
____Widowed
____Living with a partner

Is your spouse or partner overweight?
____Yes ____No

Number of children: ______
Ages:__________________

Are any of your children overweight?
____Yes ____No

What was your lowest weight in the last 5 years? __________lbs.

How often do you eat out or pick up food?
____per day
____per week

What restaurants do you frequent?
____

How often do you eat fast food?
____Daily ____Weekly

Who plans and prepares your meals?
____

Who does your grocery shopping?
____

Do you use a shopping list?
____Yes ____No

What time of day, and on what day, do you grocery shop? ______________
____

Are you allergic to any foods?
____Yes ____No
Explain_____________________

What type of foods do you dislike?
____

What type of foods do you crave?
____

Is there any specific time that you crave food?_________________________

Do you drink __coffee or __tea?
____Yes ___No
If so, how much daily? __________

Do you drink soda?
____Yes ____No
If so, how much daily? ___________
What brand/flavor? ______________

Do you drink alcohol?
____Yes ____No
What type? ____________________
How much daily? _______________

Do you use sugar substitutes?
____Yes ____No type___________

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Do you awaken hungry at night?
____Yes ____No

What are your worst eating habits?
____
____

What are your snack habits?
What? ____________________
When? _____________
How much? _________________

When you are in a stressful situation, do you tend to eat more?
____Yes ____No

Are you currently dealing with a stressful situation? ____Yes ____No

Are you an emotional eater?
____ Yes ____ no

Do you smoke? ____Yes ____No

What is your typical breakfast?
____
____
____
Time eaten: ____________
Where: ________________
With whom: ______________

What is your typical lunch?
____
____

What is your typical dinner?
____
____
____
Time eaten: _______________
Where: ___________________
With whom: ________________

____

What do you do? _______________
____
Where: ______________________
With whom: ________________

Physical Activity (check one):

Describe your typical energy level:
____

Physical acivity

____Inactive
No regular activity.
Has a sit-down job.

____Light Activity
No organized physical activity during leisure time.

____Moderate Activity
Occasionally involved in activities such as weekend golf, tennis, walking, etc. (30 minutes 3-5 times per week).

____Heavy Activity
Consistent exercise at least 60 minutes 3-5 times per week