HEALTH PLUS FOLLOW UP VISIT FORM

Name _____ Age _____ Today's Date _____

Phone Number (if changed) _____ Your Email (if changed) _____

Do you have any new medical problems or injuries since your last visit?_____

Are you taking any new medications? _____

Overall how do you think your weight loss is going: AWESOME GOOD FAIR TERRIBLE

If it is not going as well as you would like, what do you think is getting in the way? _____

_____

Are you struggling with food cravings? YES NO WHICH FOODS _____ Have you been binge eating? YES NO

Are you keeping track of your food intake? YES MOST OF THE TIME SOMETIMES NO Did you bring in a food diary with you today? YES NO

How many fat grams are you averaging per day? _____ How many times a days are you eating, including all meals and snacks? _____

Are you tracking your calories? YES NO If so, how many calories per day are you averaging? _____

How many times have you eaten out in the past week? _____ Have you eaten out at any fast food restaurants? YES NO

Have you been planning your meals and snacks ahead of time? ALL THE TIME MOST OF THE TIME SOMETIMES NO

Have you been exercising? EVERYDAY MOST DAYS SOME DAYS NO WHAT KIND OF EXERCISE _____

Have you been wearing a pedometer? EVERYDAY/ALLDAY MOST OF THE TIME, SOME OF THE TIME, NOT AT ALL

How many steps per day have you been walking? _____ What is your step goal? _____

Are you satisfied with the amount of exercise you are getting? YES NO If not, what gets in the way? _____

Have you been taking the weight loss medication prescribed at Health Plus? EVERYDAY SOMETIMES NO

If you are taking the medication, do you think it has been helpful? VERY HELPFUL A LITTLE HELPFUL NOT HELPFUL AT ALL

Have you had any side effects or problems with the medication? _____

Are there any lifestyle changes (diet, exercise, time management, shopping, etc) that you are able to commit to between now and your next visit?

_____

Do you anticipate any challenges coming up in the next few weeks? _____

_____

Do you have concerns, issues or problems that you want to discuss at today's visit? _____

_____

Are there ways that Health Plus could better serve your needs? _____

_____

DO NOT WRITE BELOW DOTTED LINE

Weight _____ B/P _____ Pulse _____

Medication _____ _____ _____

Diet _____

Exercise::_____ F/U Visit _____ wks Clinician _____