WEIGHT CONTROL
EXPECTATIONS QUESTIONNAIRE

This form has been designed to assist you in organizing your thoughts regarding exactly what it is you want for yourself. By filling out this questionnaire as completely as possible, and then reviewing it with your physician, you will learn what can reasonably be expected to occur.

How much weight do you expect to lose? ..... Each week? ..... Each month? .....

What will happen if you don't lose that much or that fast? How will you react? .....

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If your weight loss slows down markedly, or even completely stops for a while, will you understand the difference between fat loss and water loss? .....

What size clothes do you expect to be able to wear when you reach your goal weight?

.....

What do you expect from us (your medical counselors)? Be specific: .....

.....

Will it change your life in any way (for better or worse) when you reach your goal weight? .....

Do you expect to be doing anything you are not doing now? (describe in detail) .....

.....

Do you expect to STOP doing something you ARE DOING NOW? (describe in detail)

.....

Will you be able to handle compliments about how you look when you are of normal size? .....

Will your "new" normal weight self" pose a threat to your relationship with "significant others?" (how specifically?) .....

How will family and friends respond to the "new you?".....

Do you expect to get a better job? .....

Will you get more respect from other people?(Who specially).....

Will you feel comfortable with these altered responses from others? .....

Will you be expected to perform better at work (or at home)? .....

Will you have to be more sociable than you are now? .....

Will you have to assume any new responsibilities (please describe)? .....

.....

What will happen if some of your expectations don't come true? What might you do?

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What do you expect to have to do to maintain weight the same? .....

.....

Will you continue to watch your food intake? .....Exercise? .....

Continue with professional medical monitoring? .....For about how long?.....

Do you have any other expectations than those listed above?.....Specifically, what are they?

Please describe them in detail .....

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Patient Name:_____ **Date:**_____

Email Address: _____

By signing this form, I understand that I may receive email communication from The Center for Medical Weight Loss from time to time related to my weight loss program. I also understand that I may elect to stop receiving such emails at any time by using the "unsubscribe" link located at the bottom of the email communication.