KALLAL MEDICAL GROUP

# WEIGHT MANAGEMENT EXPECTATIONS QUESTIONNAIRE

*The accompanying explanatory sheet discusses the importance of clearly delineating your expectations when participating in any kind of weight control program. This form has been designed to assist you in organizing your thoughts regarding exactly what it is you want for yourself: By first 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? Per week _____ Per month _____

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

_____

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? ○ Yes ○ No

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)*? Please Be specific: _____

_____

Will it change your life in any way *(for better or worse)* when you reach your goal weight? ○ Yes ○ No

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 expected to perform better at work (or at home)? ○ Yes ○ No

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? _____

_____

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

_____

Will you continue to watch your food intake? ○ Yes ○ No Exercise? ○ Yes ○ No

Continue with professional medical monitoring? ○ Yes ○ No If Yes, for about how long? _____

Do you have any other expectations than those listed above? ○ Yes ○ No

If Yes, specifically, what are they? *(Please describe in detail)* _____

_____

_____

By signing this form, I understand that I may receive email communication from Kallal Medical Group Weight Loss Management Program 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 contacting Kallal Medical Group via email communication.

SIGNATURE AND DATE SIGNED:

PATIENT:

Patient Name *(Please Print)* _____

Patient Signature _____ Date _____

CLINICAL PRACTITIONER:

Practitioner Name *(Please Print)* _____

Practitioner Signature _____ Date _____

UPLOAD **completed form to Kallal Medical Group via secure website form.**