Weight Loss Assessment Form

Date of Service: _____ Visit #: _____

Patient's Name: _____ DOB: _____

Height:_____Weight: _____ BMI: _____

Weight Loss / Gain since last visit :_____(lbs)
(Please circle one)

Assessment:

Morbid Obesity
Diabetes
Coronary Artery Disease
Congestive Heart Failure
GERD
Obstructive Sleep Apnea
Hyperlipidemia
Hypertension
Arthritic Symptoms of the Weight-Bearing Joints

Other: _____

Plan:

• Diet Recommendation:
1200 calorie ADA diet
1400 calorie ADA diet
1600 calorie ADA diet
1800 calorie ADA diet
2000 calorie ADA diet
Low Fat Diet

Other_____

• Exercise Recommendation:
Walking 30 minutes daily 4 times week
Curves
YMCA

Other_____

Physician's Signature: _____ Today's Date: _____