

Body Shaping Profile

To help me learn more about your unique weight management needs, I'd like you to complete this Personal Body Shaping Profile. Your profile covers five important areas: (1) Weight, (2) Health, (3) Diet, (4) Activity and (5) Vitality.

It should take you around 10–15 minutes to answer the questions. All the information you provide is confidential and will not be shared with any other person without your permission. If you would rather not answer any particular question, you can leave it blank as this is OK.

Disclaimer: This profile is not a medical or health screening and you should always seek approval from your medical practitioner before starting a diet, exercise or weight loss program.



Date you completed this profile: _____

Your details

Name: _____

Address: _____

City: _____ State: _____ Postcode: _____

Telephone (W): (____) _____ Telephone (H): (____) _____

Mobile: _____ Email: _____

Date of birth: ____ / ____ / _____ Age: _____ Male Female

Occupation: _____

Marital status (optional): Married/Living with partner Never married Previously married

Do you have children? NO YES If YES, how old are they? __ / __ / __ / __ / __ years

1. Weight

I'd like you to answer some questions about your weight history to get a better picture of what you have achieved in the past and would like to achieve now.

1. What is your current weight? _____ kg / lbs and height _____ cm / ft

2. What is your current waist measurement _____ cm / in (leave blank if unsure)

3. What is your current dress/pant size _____ cm / in (leave blank if unsure)

4. Were you overweight as a child or teenager? YES NO

Your highest weight:

5. What is/was your highest weight since turning 18? _____ kg / lbs (Women: non-pregnant)

6. What is/was your age at this weight? _____ years

7. How long have you been/did you stay at this weight? _____

8. Describe your eating habits at your highest weight

9. Describe your physical activity habits at your highest weight

Your lowest weight:

10. What is/was your lowest weight since turning 18? _____ kg / lbs

11. What is/was your age at this weight? _____ years

12. How long have you been/did you stay at this weight? _____

13. Describe your eating habits at your lowest weight

14. Describe your physical activity habits at your lowest weight

15. Thinking of the effort you had to make, how hard is/was it to maintain your lowest weight?
(Circle the number representing your best response)

1	2	3	4	5
Not very hard	Not hard	OK	Somewhat hard	Very hard

16. What was your approximate weight at the ages below? (rough figures are OK here)

18 years _____ 25 _____ 30 _____ 35 _____ 40 _____ 50 _____

Your weight goals:

17. What was the specific trigger that has influenced you to take action to change your weight or shape (eg. difficulty fitting into clothes, health risk, etc)?

18. How much weight would you like to lose? _____ kg / lbs

19. Are there any specific parts of your body you should like to reshape or tone?

20. When would you like to achieve your results by? _____

21. How long have you been thinking about starting a weight loss / shape up program? _____

22. What has kept you from starting sooner? Work Family commitments
 No time No money Injury Lack of motivation Procrastination
 Other _____

23. Is this still a challenge for you? _____

24. Who of your family and friends supports you in starting a weight loss / shape up program?

2. Health

I'd like you to answer some questions about your general health history. This is not a medical screening and you should always seek your doctor's approval before starting a program.

25. Do you have, or have you ever had any of the following? (please tick)

High blood pressure High cholesterol or triglycerides Heart condition
 Glucose intolerance or diabetes Sleep apnoea Back pain PCOS (women)

26. Do you smoke? NO YES, how many cigarettes on average each day? _____

27. Are you aware or has your doctor ever told you that there is any medical reason why you may find it harder to lose weight? YES NO

27A. If YES, please write _____

28. Are you taking any medications that your doctor has told you may reduce or improve your ability to lose weight or change shape? YES NO

28A. If YES, please write _____

29. Are you aware or has your doctor ever told you that you have any medications, injuries, conditions or discomfort that may limit your ability to exercise (eg. heart disease, sore knees)? YES NO

30. If YES, please write _____

31. Have you ever suffered from an eating disorder? YES NO

3. Diet

32. Are you currently following any special diet or eating program? YES NO

33. If Yes, please describe _____

34. What, if any diets have you tried in the past? _____

35. Which best describes your current eating pattern? Grazing throughout the day
 Three meals a day Three meals, plus snacks Often skipping meals / no pattern

36. In a typical 7-day week, how many days would you eat lunch in the following places?
____ Home ____ Work ____ Restaurant ____ Mall ____ On the go ____ I skip it

37. In a typical 7-day week, how many days would you eat the dinners on the next page?
 ____ Cooked dinner ____ Heat pre-packaged / frozen meals at home
 ____ Order in takeaway or eat out What do you usually have? _____
38. Who usually does the cooking at home? Me My partner (tick both if you share)
39. Who does the food shopping? Me My partner (tick both if share / shop together)
40. How many days a week do you eat breakfast? _____ days
41. How many days a week do you drink alcohol? _____ days
42. On days you drink alcohol, how many drinks would you usually have? _____ drinks
 (1 drink = approx. 285 mL beer, 100 mL wine, 60 mL port/liqueur, 30 mL spirits)
43. How many glasses of water (250 mL) would you usually drink each day? _____ glasses
44. When I'm feeling stressed, I eat? More Less About the same
45. When I'm feeling bored, I eat? More Less About the same

For the following statements, tick whether they tend to apply to you:

46. I snack too often or eat more than I should?
 Yes No Sometimes
47. When dieting, I tend to dwell on forbidden foods that I can't eat?
 Yes No Sometimes
48. When I slip off a diet I feel that I have failed?
 Yes No Sometimes
49. I feel confident reading nutrition information on food labels?
 Yes No Sometimes

4. Activity

50. Are you currently doing any physical activity? YES NO

If YES, continue next question. If NO, go to question 53 on the next page.

51. What type of physical activity? _____
52. How many times per week? _____
53. How long have you been doing it? _____
54. Are you getting the results you want from your physical activity? YES NO
55. If Yes, would you like to make any changes to your physical activity routine?

56. If No, describe what is not working with your current physical activity routine?

If NO:

57. Have you ever done any physical activity? YES NO (If NO, go to next section)

58. What was it? _____

59. How long ago? _____ Times per week? _____

60. Did you get the results you wanted? YES NO

61. Can you tell me why you stopped? _____

5. Vitality

I'd like you to answer some questions about how you generally feel. Think about each question carefully, and circle the number that gives your most honest rating.

62. I feel energetic, vigorous and full of pep?

Rarely							Almost always
1	2	3	4	5	6	7	

63. I get a good night's sleep?

Rarely							Almost always
1	2	3	4	5	6	7	

Note: The scoring for the next 3 questions has 'Rarely' to the right hand side.

64. I feel tense, anxious or stressed?

Almost always							Rarely
1	2	3	4	5	6	7	

65. I feel worn out or sluggish?

Almost always							Rarely
1	2	3	4	5	6	7	

66. I feel sad, discouraged, or gloomy?

Almost always							Rarely
1	2	3	4	5	6	7	

67. Compared to previous attempts, how motivated to lose weight are you now? (circle one)

1 Not at all 2 Slightly 3 Somewhat 4 Quite 5 Extremely

68. How confident are you that you will be able to stay committed to reach your goals? (circle one)

1 Not at all 2 Slightly 3 Somewhat 4 Quite 5 Extremely

Thankyou for completing this profile.