Weight Loss Management Clinic
Social Work Evaluation

Name: _____ Age: _____

Where do you live now? _____
Who lives at home with you? _____
Who are the supportive people in your life? _____
How do you think they will support you in your weight loss journey? _____
_____

What are your goals for enrolling in the Weight Loss Management Program? Please be specific.
1) _____
2) _____

What are the benefits of working towards these goals?

1) _____
2) _____

What are the benefits of keeping things the way they are?
1) _____
2) _____

Employment history

Are you currently working? ☐Yes ☐ No Profession: _____
Are you receiving disability benefits? ☐Yes ☐ No If yes, sources: _____

What is your current insurance? _____
Do you have a secondary insurance? _____

Mental Health
Do you have any mental health diagnoses? ☐Yes☐ No
If yes, please list diagnosis_____

Have you had concerns about your mood over the past 12 months? ☐Yes ☐ No
If so please describe: _____

Have you ever been hospitalized for mental health reasons?
☐Yes ☐ No If so, dates: _____

Have you ever attempted to harm yourself or others?
☐Yes ☐ No If so, dates: _____

Are you currently under the care of a counselor? ☒Yes ☐ No
If so, Name: _____ Agency: _____

Are you currently taking any medications for your mental health? ☐Yes ☐No
If so, which ones? _____

Please list any mental health treatment you have had in the past (be as specific as possible):

Dates	*Type of Treatment*	*Reason for Termination*

Have you experienced abuse or mistreatment in any of your relationships? ☐ Yes ☐ No
If so, please explain_____

Have you ever experienced an eating disorder? ☒Yes ☐ No
If yes, please explain. _____
_____

What do you do to cope with difficult situations? _____
_____

What are your favorite hobbies? _____

What do you like to do for physical activity? _____

Substance Use

Do you smoke, or have you smoked in the past? _____

Do you drink alcohol, or have you drunk in the past? _____

Do you use recreational drugs, or have you used them in the past?
_____

Have you ever felt you should cut down on your drinking or drug use? _____
Have people ever annoyed you by criticizing you're drinking or drug use?
_____
Have you ever felt bad or guilty about your drinking or drug use? _____
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? _____

Thank you for completing this questionnaire!