

Patient: \_\_\_\_\_ Contract Number: \_\_\_\_\_ Chart: \_\_\_\_\_

**PLEASE COMPLETE FOR THE LAST FIVE (5) YEARS**

**Please be as thorough as possible. List all diets whether they are supervised or unsupervised.**

***Month and year must be specified for each diet.***

Type of Weight Loss Program	Number of times tried	How long did you follow the diet?	When did you follow the diet? <i>Month, Year</i>	What were the results? (Long term and short term)
Weight Watchers				
Physician supervised diets				
TOPS				
Overeaters Anonymous				
Prescription diet pills				
Behavior Modification				
Psychotherapy (group or individual)				
Unsupervised diets (Slim Fast, calorie counting, etc.)				
Other				
Other				
Other				