FUNCTIONAL MEDICINE WEIGHT MANAGEMENT
SCREENING QUESTIONNAIRE

NAME: _____ DATE: _____

INSTRUCTIONS: Please circle the number of any statement that applies to you.

Lifestyle Section

1. I eat out ten or more times in a week.
2. I consume 14 or more alcoholic drinks in a week
3. I seldom eat more than two servings (combined) of fruit and vegetables daily.
4. I consume more than 20 oz of soft drink daily.
5. I seldom exercise 60 minutes or more in a week.
6. I consume refined sugar/carbohydrates at least several times daily.
7. I frequently eat between meals.
8. Foods such as hamburgers, hot dogs, pizza, fried chicken, fries or chips are consumed almost every day.
9. I have a problem with stress eating or compulsive eating.

Total Circled: _____

Syndrome X Section

1. My family history is positive for Diabetes Mellitus.
2. My past medical history is positive for high triglycerides.
3. My past medical history is positive for infertility, unwanted facial hair, or cysts on the ovary.
4. I frequently crave sugar and/or carbohydrates.
5. I experience erratic energy and/or mood swings that can be affected by eating.
6. I gain weight in the upper body or apple distribution.
7. I experienced gestational diabetes and/or delivered a baby that weighted more than nine pounds.
8. My past medical history is positive for borderline or confirmed high blood pressure.
9. My past medical history is positive for gout.
10. My ethnic roots are non-European.

Total Circled: _____

Food Allergy/Hypersensitivity Section

1. As an infant or small child I had problems with colic, allergies or recurrent respiratory infections.
2. I have a past or current medical history of asthma.
3. I have a past or current medical history of chronic nasal or sinus problems.
4. I have a past or current medical history of hives or eczema.
5. I have a past or current medical history of Irritable Bowel Syndrome.
6. I have a past or current medical history of excessive headaches.
7. I have a past or current medical history of musculoskeletal aches and pains.
8. I eat a lot of wheat or milk-based foods.

Total Circled: _____

Endocrine Section

1. My family history is positive for thyroid problems.
2. I am frequently cold when others are comfortable.
3. My face and body are often puffy or swollen.
4. I am very sluggish in the morning and have difficulty getting up.
5. My hair appears to be less healthy or is falling out.
6. My skin has become too dry.
7. My nails are brittle.
8. I have a history of high cholesterol.
9. I am taking Synthroid or other thyroid replacement.
10. I experience craving and weight gain with PMS.
11. My weight gain has been associated with going through the premenopause or menopause.
12. My weight gain has been associated with taking hormone replacement therapy or the birth control pill.
13. I have significant issues with decreased libido.
14. My weight gain has coincided with very high stress
15. I have gained weight distributed in my upper back below the neck level.

Total Circled: _____

Chronic Illness Section

1. I started gaining weight after I contracted a chronic illness.
2. I have a chronic illness, e.g., Chronic Fatigue Syndrome, Fibromyalgia, Rheumatoid Arthritis, etc…
3. I frequently feel exhausted.
4. I frequently feel sick all over, like having the flu or Mono.
5. I am very sensitive to medications
6. I am very sensitive to smoke, chemicals or fumes in the environment.
7. I am presently or have in the past taken a lot of Prednisone, NSAISDS (eg, Motrin, Advil, Ibuprofen), antibiotics, antidepressants or other medications I suspect have contributed to my weight gain.
8. Due to my illness, I am quite sedentary.
9. I have had frequent yeast infections (including thrush).

Total Circled: _____

Social History

1. How many hours of sleep do you typically get a night?
   ____ Less than 6 ____6-8 ____8-10 ____More than 10

2. Do you wake well rested and refreshed? Yes____ No____

3. Are you fatigued at any particular time of the day? Yes____ No____
   If yes, when?
   ____Morning ____Afternoon ____After a meal

4. Has your weight changed significantly over the past 5 years? Yes____ No____
   If so, how much
   ____increased over 20 pounds
   ____decreased over 20 pounds

5. Are you currently or have you recently been a tobacco smoker? Yes____ No____
   If yes, how much
   ____1 or less packs of cigarettes/day
   ____more than 1 pack/day

6. How many cups/glasses per day or week do you drink of the following
   (ex: 2/d coffee, 1/w beer)
   ____water ____cola drinks ____whiskey
   ____decaf coffee ____red wine ____other carbonated drinks
   ____black tea ____coffee ____beer
   ____other soft drinks ____other alcoholic drinks

7. What type of diet are you on?
   ____Standard American Diet
   ____Vegan ____Low-carb ____ Dairy restricted
   ____Vegetarian ____Ovo-lacto ____Other (specify:_____)
   ____Low-fat ____Diabetic

8. Please indicate your exercise habits below. Enter time spent on each activity in the appropriate frequency box.

Type of Exercise	**Frequency (times/week) – minutes**					
	0	1	2	3	4	5+
AEROBIC						
RESISTANCE TRAINING						