

Name \_\_\_\_\_ Section \_\_\_\_\_ Date \_\_\_\_\_



## WELLNESS WORKSHEET 83

### Checklist for Evaluating Weight-Loss Products and Services

Use this checklist to gather and compare information from all weight-loss programs you're considering. Make several copies of the blank form so you can fill out one for each program. A provider's willingness to give you this information is an important factor in choosing a program. If you need help to evaluate the information you gather, talk with your primary health care provider or a registered dietitian.

Program Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone Number \_\_\_\_\_

In this program, my daily caloric intake will be: \_\_\_\_\_

My daily caloric intake is determined by: \_\_\_\_\_

I  will  will not be evaluated initially by program staff.

The evaluation will be made by (check all that apply):

Physician       Nurse       Registered Dietitian       Other company-trained employee

My progress is supervised by (check all that apply):

Physician       Nurse       Licensed Psychologist  
 Registered Dietitian       Company-trained employee

I  will  will not be evaluated by a physician during the course of my treatment.

During the first month, my progress will be monitored:

Weekly       Biweekly       Monthly       Other \_\_\_\_\_

After the first month, my progress will be monitored:

Weekly       Biweekly       Monthly       Other \_\_\_\_\_

My weight-loss plan includes (check all that apply):

Nutrition information about healthy eating       At least 1200 calories/day for women or 1400 calories/day for men  
 Suggested menus and recipes       Keeping food diaries or other monitoring activities  
 Portion control       Liquid meal replacements  
 Prepackaged meals       Dietary supplements (vitamins, minerals, botanicals, herbals)  
 Prescription weight-loss drugs       Help with weight maintenance and lifestyle changes  
 Surgery

(over)

WELLNESS WORKSHEET 83 — continued

My plan includes regular physical activity that is (check both if both apply):

- Supervised (at the program site) \_\_\_\_\_ times per week, \_\_\_\_\_ minutes per session.
- Unsupervised (on my own time) \_\_\_\_\_ times per week, \_\_\_\_\_ minutes per session.

The physical activity includes (check all that apply):

- Walking       Swimming       Stationary cycling
- Strength training    Aerobic dancing    Other \_\_\_\_\_

The weight-loss plan includes (check all that apply):

- Family counseling       Group support       Lifestyle modification advice
- Weight maintenance advice       Weight maintenance counseling

The staff explained the risks associated with this weight-loss program. They are:

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The staff explained the costs of this program. (Check all that apply and fill in the blanks.)

- I will be charged a one-time entry fee of \$ \_\_\_\_\_.
- I will be charged \$ \_\_\_\_\_ per visit.
- Food replacements will cost about \$ \_\_\_\_\_ per month.
- Prescription weight-loss drugs will cost about \$ \_\_\_\_\_ per month.
- Vitamins and other dietary supplements will cost about \$ \_\_\_\_\_ per month.
- Diagnostic tests are required and will cost about \$ \_\_\_\_\_.
- Other costs include \_\_\_\_\_ at \$ \_\_\_\_\_.

**Total cost for this program \$ \_\_\_\_\_**

The program gave me information about:

- The health risks of being overweight.     The difficulty many people have maintaining weight loss.
- The health benefits of weight loss.       How to improve my chances at maintaining my weight.

Other information to ask for:

- Participants in this program have lost an average of \_\_\_\_\_ lbs. over \_\_\_\_\_ months/years.
- Participants in this program have kept off \_\_\_\_\_ % of their weight loss for \_\_\_\_\_ year(s).

This information is based on the following (check one):

- All participants.
- Participants who completed the program.
- Other \_\_\_\_\_

Notes:

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