Name: ______________________________ **Goal Weight:** __________ **# of Sessions** _______

Consultation Date:	Session	1	2	3	4	5	6	7	8	9	10	11	12
Consultation Weight:	Date												
	Weight												
	Gain/Loss												
Exercise													
Problem Foods: Lose Desire For													
Stop Using Salt:													
Skip Meals:													
Portions:													
Fork / Slow Down:													
Drink More Water:													
Increase Desire:													
Stop Snacking:													
Self Esteem													
Stress													
Other													

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Commitment ________%

Discomfort ________%

Inner Control ________%

Perfectionism ________%

Secondary Gain ________%

Stress Eating ________%

Commitment ________%

Discomfort ________%

Inner Control ________%

Perfectionism ________%

Secondary Gain ________%

Stress Eating ________%