

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



## Lab A9-7 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)

**LAB A9-7** (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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