



Weight Management Program Survey

Program Name: _____
 Street: _____ City: _____
 ZIP: _____ County: _____ Phone: _____ - _____ - _____

Does this program specifically address weight management and include group or individual counseling and support for increased physical activity, better eating and behavior change? Y N

Multi-Site Program: Y N *(Please list additional NC program sites on another sheet)*

Website: _____

Years in operation:

- Less than one year Four to 10 years
 One to three years More than 10 years

DESCRIPTION OF SERVICES PROVIDED

Service	Part of core program?	Available at additional fee?	Qualifications of individuals providing this service <i>(see options below, select all that apply*)</i>
One – on – one counseling	Y N	Y N	
Group instruction or support	Y N	Y N	
Weigh -ins	Y N	Y N	
Fitness/exercise	Y N	Y N	
Personal Training	Y N	Y N	
Behavior Modification	Y N	Y N	
Healthy cooking instruction	Y N	Y N	
Maintenance program once weight loss achieved	Y N	Y N	
Support Group	Y N	Y N	
Pre-program medical or clinical assessment	Y N	Y N	

- 1= Register dietitian 5= Clinical psychologist 8=Internal training program
 2= Exercise physiologist 6= Health Educator 9= Successful client
 3 = Certified personal trainer 7 = Nurse (RN, LPN) 10 = Other
 4= Written materials only, no personal instruction

Is this a "live – in" program: Y N

Type of Eating Plan(s) Offered

(check all that apply):

- Balanced reduced calorie
- Very low calorie (800 calories per day or less)
- Low carbohydrate
- Low fat/very low fat
- Other: _____

Does the program offer pre-packed food, meal replacements or supplements: Y N

If yes: are clients required to buy pre-packaged foods, meal replacements or supplements: Y N

PROGRAM DURATION:

- Weight loss:**
- Six weeks or less
 - Two – four months
 - Duration based on individual needs
 - Other: _____

MEETING FREQUENCY:

- Daily or several times per week
- Once per week
- Two to three times per month
- Once per month
- Based on individual needs
- Other: _____

Maintenance: Not offered

- Six weeks or less
- Two – four months
- More than four months
- Duration based on individual needs

- Daily or several times per week
- Once per week
- Two to three times per week
- Once per month
- Based on individual needs
- Quarterly
- Other: _____

Is the program certified by the North Carolina Board of Dietetics/Nutrition? Y N

If yes, what is the certification date? _____

If no, is this program owned or operated by a licensed, registered dietitian? Y N

If yes, what is the name of the dietitian? _____

PROGRAM COSTS (please use average costs for core program for the following sections):

One Time Enrollment Fees:	Average Weight Loss Phase (excluding food):	Required Foods (per week):	Maintenance Phase:
<input type="checkbox"/> Not applicable	<input type="checkbox"/> Less than \$50	<input type="checkbox"/> Not applicable	<input type="checkbox"/> Not applicable
<input type="checkbox"/> Less than \$50	<input type="checkbox"/> \$50 to \$200	<input type="checkbox"/> Less than \$50	<input type="checkbox"/> Less than \$50
<input type="checkbox"/> \$50 to \$200	<input type="checkbox"/> \$200 to \$500	<input type="checkbox"/> \$50 to \$200	<input type="checkbox"/> \$50 to \$200
<input type="checkbox"/> \$200 to \$500	<input type="checkbox"/> More than \$500	<input type="checkbox"/> \$200 to \$500	<input type="checkbox"/> \$200 to \$500
<input type="checkbox"/> More than \$500		<input type="checkbox"/> More than \$500	<input type="checkbox"/> More than \$500

Please Include/Attach any Published Outcomes or internal program evaluation data if available:

- Information is attached
- No information available at this time

Enrollment Process:

Can individuals begin program at any time?

- Yes
- Only when new classes/sessions are starting
- Other: _____

Pre-enrollment Requirements:

- None
- Medical assessment or physical by clients own doctor or by the program
- Completion of a health assessment or health history

Can clients with the following conditions participate in the program:

- Pregnancy
- Lactating
- Cardiac condition
- Diabetes

Ages of Clients Accepted into the Program:

- 12 years and under
- 13 - 17
- 18 and Older
- Families – both parents/guardians and children

Other general comments about your program: _____

**Please send completed survey to: NCAHC Weight Management Registry Project Manager
PO Box 4293
Greensboro, NC 27404-4293**

Or fax the completed and signed survey to Betsy LaForge at 919-765-4303

Authorization and Release. The undersigned, a duly appointed officer of the above-referenced Program, authorizes NCAHC to disseminate information provided in this Survey and acknowledges that the information provided by the Program will be included in the Website of NCAHC and that NCAHC is hereby released from any and all liability relating to the disclosure of information contained herein. The undersigned also agrees that, unless and until NCAHC is notified by program that information contained in this survey is no longer accurate, NCAHC shall have no responsibility for updating information provided on its website regarding its program.

NAME OF PROGRAM SPONSOR

Name (print): _____

Title: _____

Signature: _____

Date: _____