

Have you tried any of the following in the past to lose weight?

Dietitian or Nutritionist?	Y	N	
Exercise?	Y	N	
Low calorie diet?	Y	N	
Formal group diet program? (e.g. Weight Watchers, Overeaters Anonymous, etc.)	Y	N	Which one? _____
Prescription diet medications (please circle all you have taken)? phenfluramine fenfluramine fen/phen Redux Meridia Xenical Other_____	Y	N	
Over-the-counter diet preparations, including any herbal products? (e.g. Dexatrim, ephadra, et al) Which one? _____	Y	N	
Psychological counseling / Behavioral modification?	Y	N	
Hypnosis?	Y	N	
Do you ever induce vomiting? If 'yes', how frequently? _____	Y	N	
Do you ever use laxatives to help lose weight? If 'yes', how frequently? _____	Y	N	

Did you maintain your weight loss for at least 1 year after finishing the above method? Y N

If 'no', why do you think you were not successful? _____

Are you using any of the above methods currently? Y N Which one? _____

Do any of the following apply you?

Do you eat when you are upset or nervous?	Y	N
Do you have a "sweet tooth" (i.e. eat a lot of candies, pastries, etc.)?	Y	N
Do you tend to binge eat (i.e. eat very large amounts at one sitting)?	Y	N
Do you tend to wake up at night to eat?	Y	N

Tobacco and Alcohol Use

Please indicate your usual number of alcoholic drinks:

(1 drink = 1 oz. hard liquor, or 4 oz. wine, or 12 oz. beer)

- (a) None
- (b) Less than 1 drink/week
- (c) 2-7 drinks/week
- (d) 8-14 drinks/week
- (e) 15-21 drinks/week
- (f) more than 21 drinks/week

Do you smoke cigarettes? Y N

If 'yes', for how many years have you been smoking? _____

If 'yes', please indicate usual number of cigarettes/day: less than 5 5-14 15-29 30+

If 'no', have you ever smoked? Y N

If 'yes', please indicate at what age did you start and quit smoking? _____

If you have ever had a problem with alcohol or drug consumption, please describe the problem and any help you have received: _____

Eating Patterns - Part I

Please pick the number that best describes how much the behavior influences your weight gain.

- 1 = does not contribute
- 2 = contributes a small amount
- 3 = contributes a moderate amount
- 4 = contributes a large amount
- 5 = contributes the greatest amount

- _____ eating too much food
- _____ overeating at breakfast
- _____ overeating at lunch
- _____ overeating at dinner
- _____ snacking between meals
- _____ snacking at night
- _____ eating because I feel physically hungry
- _____ eating because I crave certain foods
- _____ eating because I cannot stop once I have begun
- _____ continuing to eat because I don't feel full after a meal
- _____ eating because of the good taste of food
- _____ eating because of the sight / smell of food
- _____ eating while cooking or preparing food
- _____ eating when anxious
- _____ eating when tired
- _____ eating when bored
- _____ eating when angry
- _____ eating when depressed / upset
- _____ eating when socializing
- _____ eating when happy
- _____ eating when alone

Please indicate any other factors that you feel have contributed to your weight gain.

How many days a week do you eat the following meals?

(Please estimate the number of days and the usual time of each meal.)

Meal	days/week	time
Breakfast	_____	_____
AM snack	_____	_____
Lunch	_____	_____
Afternoon snack	_____	_____
Dinner	_____	_____
Nighttime snack	_____	_____

Who prepares the meals at home? _____

Who does the grocery shopping? _____

List your favorite foods: _____

Please estimate as best you can the amount (in 8-oz. Cups) of the following fluids you typically consume per day:

- _____ Skim milk
- _____ Low fat milk ___ 1% ___ 2%
- _____ Whole milk
- _____ Seltzer water
- _____ Fruit juice
- _____ Water
- _____ Coffee
- _____ Tea
- _____ Regular soda
- _____ Diet soda
- _____ Other: _____

During a typical week, how many meals do you eat at a fast-food restaurant?

(Please include meals bought in drive-throughs and convenience stores.)

- Breakfast _____
- Lunch _____
- Dinner _____
- Snacks _____

During a typical week, how many meals do you eat at a traditional restaurant, coffee shop, cafeteria, or similar establishment?

- Breakfast _____
- Lunch _____
- Dinner _____
- Snacks _____

(Please continue on next page.)

Food Recall

Please indicate the foods and fluids you consume on a **typical weekday**. Give your best estimates.

Meal	Time	Location	Food / Beverage Consumed (Include how prepared.)	Amount
Breakfast				
AM Snack				
Lunch				
Afternoon Snack				
Dinner				
Nighttime Snack				

Please indicate the foods and fluids you consume on a **typical weekend day**.

Meal	Time	Location	Food / Beverage Consumed (Include how prepared.)	Amount
Breakfast				
AM Snack				
Lunch				
Afternoon Snack				
Dinner				
Nighttime Snack				

Eating Patterns – Part II

During the last 6 months, did you often eat an unusually large amount of food within a 2-hour period? Y N

Did you usually have any of the following experiences during these occasions?

Eating much more rapidly than usual? Y N

Eating until you felt uncomfortably full? Y N

Eating large amounts of food when you did not feel physically hungry? Y N

Eating alone because you felt embarrassed by how much you were eating? Y N

Feeling disgusted with yourself, depressed, or feeling very guilty after overeating? Y N

Eating large amounts of food throughout the daytime with no planned mealtimes? Y N

At the time these episode start, estimate how long has it been since you previously finished eating a meal or snack? _____ hours _____ minutes

Do you eat most of your meals

_____ alone

_____ with others

_____ in front of the TV or the computer?

During the last 3 months, did you ever fast (not eat anything for at least 24 hr.) to avoid gaining weight? Y N

If 'yes', how often on average did you fast (per week)?

_____ less than once per week

_____ once per week

_____ 2-3 / week

_____ 4-5 / week

_____ more than 5 times / week

How often more than 24 hours at a time? _____

During the last 3 months, did you ever exercise more than 1 hour in order to avoid gaining weight after eating? Y N

If 'yes', how often on average was that (per week)?

_____ less than once per week

_____ once per week

_____ 2-3 / week

_____ 4-5 / week

_____ more than 5 times / week

How often more than 1 hour at a time (per week)? _____

Eating Patterns – Part III

In reference to the past 6 - 12 months please circle ONE answer for each question.

What level of appetite do you usually have in the morning?

- (a) none
- (b) very little
- (c) little
- (d) moderate
- (e) large

How long after you get out of bed in the morning do you wait to eat?

- (a) 0 - 2 hours
- (b) 2 ½ - 4 hours
- (c) 4 ½ - 6 hours
- (d) over 6 hours

Do you snack in the middle of the night?

- (a) never
- (b) sometimes
- (c) half the time
- (d) usually
- (e) always

How much of your daily food intake do you consume after dinner?

- (a) 0 – 25 %
- (b) 25 – 50%
- (c) 50 – 75%
- (d) Over 75%

To what extent do you have cravings or urges to eat snacks after dinner but before bedtime?

- (a) none at all
- (b) a little
- (c) somewhat
- (d) very much
- (e) extremely

To what extent do you have cravings or urges to eat snacks when you wake up at night?

- (a) none at all
- (b) a little
- (c) somewhat
- (d) very much
- (e) extremely

If you snack in the middle of the night, how aware are you of your eating?

- (a) unaware
- (b) mostly unaware
- (c) partially aware
- (d) mostly aware
- (e) completely aware
- (f) I do not snack in the middle of the night

How long has your current pattern of night eating been going on?

- (a) I never had a pattern of eating at night
- (b) 1 - 3 months
- (c) 3 - 6 months
- (d) 6 - 12 months
- (e) longer than 1 year

Physical Activity

Please describe any physical problems that limit your physical activity: _____

To what extent do you enjoy being physically active?

- (a) not at all
- (b) slightly
- (c) moderately
- (d) greatly

Please circle the types of physical activity you enjoy and that you participated in during the past year.

I enjoy	I have participated	(type of activity)
_____	_____	walking (outdoors)
_____	_____	walking (indoors)
_____	_____	jogging
_____	_____	running
_____	_____	biking
_____	_____	aerobics
_____	_____	tennis/racket sport
_____	_____	swimming
_____	_____	basketball
_____	_____	golf
_____	_____	dancing
_____	_____	strength training
_____	_____	other

Please indicate frequency and time spent on physical activity at the intensity levels below over the past 2 months.

(Use the following keys for frequency and time.)

frequency	time
(A) 6-7x/week	(1) over 30 minutes
(B) 3-5x/week	(2) 20-30 minutes
(C) 1-2x/week	(3) 10-20 minutes
(D) a few times/month	(4) less than 10 minutes
(E) less than once a month	

frequency	time	intensity
_____	_____	intense aerobic activity that result in heavy breathing and sweating (e.g. high impact aerobics, running, speed swimming, distance cycling)
_____	_____	moderate aerobic activity (e.g. normal bicycling, jogging, low impact aerobics)
_____	_____	modest aerobic activity (e.g. volleyball, moderate speed walking)
_____	_____	mild aerobic activity (e.g. normal walking, golf)

Family and Support Groups

Marital status

- Single
- Married
- Divorced
- Separated
- Widowed

If you live with another person(s), do they support your efforts to lose weight? Y N

Do you have a person(s) who will support your weight loss efforts? Y N

Living situation *(circle all that apply.)*

- Alone
 - With spouse / partner
 - With children
 - With parents / stepparents
 - With other relatives
 - With room/housemates
-

Psychological Factors

Have you ever had any problems with depression, anxiety, or other emotions that disrupted your normal functioning? Y N

During the past month have you felt depressed, sad, or blue much of the time? Y N

Pick the sentence that best describes your overall feeling about yourself: "In general, I am..."

- very happy with who I am
- happy with who I am
- okay with who I am but have mixed feelings
- unhappy with who I am
- very unhappy with who I am

Pick the sentence that best describes you: "as compared with most people, I think I have..."

- very good self-esteem
- good self-esteem
- average self-esteem
- poor self-esteem
- very poor self-esteem

Have you ever been subjected to physical abuse? Y N

Have you ever been subjected to sexual abuse? Y N

Please indicate if you are currently experiencing any stress in your life related to the following:

- | | | |
|-------------------------------------|---|---|
| Work | Y | N |
| Health | Y | N |
| Relationship(s) with other(s) | Y | N |
| Activities related to your children | Y | N |
| Activities related to your parents | Y | N |
| Legal / financial trouble | Y | N |
| School | Y | N |
| Moving | Y | N |
| Other: _____ | | |

If 'yes' please explain briefly. _____

How motivated are you to lose weight at this time (on a scale from 1 to 10, with 1="not motivated" and 10="greatest motivation you have ever had")? _____

What has prompted you to lose weight at this time? _____

People who want to achieve long-term weight control need to spend at least 30 minutes a day, for a minimum of 6 months, trying to change their eating, exercising, and thinking habits. Which of the following best describes you?

- I definitely will not be able to devote 30 minutes daily to weight control.
- I'm not sure if I can find 30 minutes daily for weight control.
- I can definitely find 30 minutes daily for weight control.
- I can devote more than 30 minutes daily to weight control.

Rate how confident you are that you will be able to significantly change your eating and exercising habits (on a scale from 1 to 10, with 1="not at all confident" and 10="extremely confident")? _____

Please use this space to discuss any other information that you think is pertinent to you in achieving successful weight loss in this program. _____
