

Please describe briefly what this person does to either help or hinder your efforts to lose/gain weight: _____

RECENT CHANGES OR STRESSORS:

- | | | |
|---|--|--|
| <input type="checkbox"/> Move to new home | <input type="checkbox"/> New job | <input type="checkbox"/> Loss of a job |
| <input type="checkbox"/> Change in living situation | <input type="checkbox"/> Birth of a child | <input type="checkbox"/> Death in family |
| <input type="checkbox"/> Major illness in family member | <input type="checkbox"/> Separation or divorce | <input type="checkbox"/> Death of a friend |
| <input type="checkbox"/> Other _____ | | |

WEIGHT GOALS:

Height: _____ Current weight: _____ Goal weight: _____

When did you last weigh this amount? _____

How long was this weight maintained? _____

At this time, do you feel that you are....

- | | | |
|--|---|---|
| <input type="checkbox"/> Very underweight | <input type="checkbox"/> Somewhat underweight | <input type="checkbox"/> About the right weight |
| <input type="checkbox"/> Somewhat overweight | <input type="checkbox"/> Very overweight | |

How satisfied are you with your :

	Very dissatisfied		Neutral		Very Satisfied
	1	2	3	4	5
Height	_____	_____	_____	_____	_____
Weight	_____	_____	_____	_____	_____
Body shape	_____	_____	_____	_____	_____
Waist	_____	_____	_____	_____	_____
Hips	_____	_____	_____	_____	_____
Thighs	_____	_____	_____	_____	_____
Stomach	_____	_____	_____	_____	_____
Face	_____	_____	_____	_____	_____
Body build	_____	_____	_____	_____	_____
Shoulders	_____	_____	_____	_____	_____

During the past six months, how important has your weight or shape been in how you feel about yourself ?

- Weight and shape were not very important.
- Weight and shape played a part in how I felt about myself.
- Weight and shape were among the main things that affected how I felt about myself.
- Weight and shape were the most important things that affected how I felt about myself.

WEIGHT HISTORY:

At what age were you first overweight/underweight by 10 lbs or more? _____ yrs old

How do you remember that you were overweight/underweight at this time? (pictures, clothes size, others telling you)

What has been your highest weight after age 21? _____ lbs at _____ yrs old

What has been your lowest weight (not due to illness) after age 21, which you have maintained for at least 1 year?

_____ lbs at _____ yrs old, maintained for _____ yrs

Was that weight reached after a weight loss effort? _____ Yes _____ No

How often do you weigh yourself? _____ never _____ occasionally _____ weekly _____ daily

_____ more than once daily

Have you ever avoided medical care because you didn't want to get on a scale and/or get a lecture about your

weight from a health care provider? _____ Yes _____ No

What was your weight: 6 months ago? _____ lbs 1 year ago? _____ lbs 2 years ago? _____ lbs

Please list all weight loss interventions you have tried in the past 10 years, including the amount of time you spent with the program/professional/diet and the outcome. Examples include the following: Weight Watchers, Jenny Craig, Ornish, Zone, Atkins, private or group sessions with a nutritionist or dietitian, personal change of lifestyle habits, hospital based medical weight loss program, gastric bypass, and lap band.

Weight Loss Method	Approximately what year	How long spent with program	Outcome with program/professional/diet

Have you done any of the following things in order to lose weight or keep from gaining weight in your adult life?

	Yes	No
fasted	_____	_____
ate very little food	_____	_____
took diet pills	_____	_____
made yourself vomit (throw up)	_____	_____
used laxatives	_____	_____
used diuretics (water pills)	_____	_____
used food substitute (powder/special drink)	_____	_____
skipped meals	_____	_____
smoked cigarettes	_____	_____

In the past year, have you had any of the following eating disorders? (Mark all that apply)

_____ Anorexia nervosa _____ Bulimia Nervosa _____ Binge eating disorder _____ None of the above

Has a doctor ever told you that you have an eating disorder such as Anorexia nervosa, Bulimia nervosa, or Binge eating disorder? _____ Yes _____ No

In the past year, have you ever eaten so much food in a short period of time that you would be embarrassed if others saw you (binge-eating)? _____ Yes _____ No

If your answer is no, skip the next 5 questions.

During the times when you ate this way, did you feel you couldn't stop eating or control what or how much you were eating? _____ Yes _____ No

How often, on average, did you have times when you ate this way—that is, large amounts of food plus the feeling that your eating was out of control?

_____ Nearly every day _____ A few times a week _____ A few times a month
_____ Less than once a month

In general, how upset were you by overeating (eating more than you think is best for you)?

_____ Not at all _____ A little _____ Some _____ A lot

Circle the example below that is similar to the largest amount of food you have ever eaten in less than two hours (even if you did not eat exactly the same foods);

Example 1: Less food than in Example 2.

Example 2: Two doughnuts and a cup of ice cream and two cookies.

Example 3: Four doughnuts and a pint of ice cream and five cookies.

Example 4: Six doughnuts and a quart of ice cream and ten cookies.

Example 5: Eight doughnuts and a half gallon of ice cream and fifteen cookies.

Example 6: More food than in Example 5.

How many times have you ever eaten the amount of food you circled above?

1 or 2 times only 3 to 12 times 13-24 times 25-50 times
 more than 50 times

Have you ever received treatment for an eating disorder of any kind? Yes No

If yes, describe all forms of treatment that you have received either currently or in the past:

(OP= outpatient; IP=inpatient; PHP= Partial Hospitalization Program)

Treatment	Approximate Dates	Provider/Location **Please list all supervising team professionals where applicable, including physician, psychiatrist, therapist, RD
Individual psychotherapy, OP		
Individual R.D./nutritionist, OP		
Group therapy		
Family therapy		
Day Program or PHP		
Inpatient treatment: medical, psychological, or both		

YOUR EATING HABITS...WHEN, WHY, AND WHAT ?

During the past week, how many days did you eat breakfast?

Never 1-2 days 3-4 days 5-6 days every day

During the past week, how many days did you eat lunch?

Never 1-2 days 3-4 days 5-6 days every day

During the past week, how many days did you eat dinner?

Never 1-2 days 3-4 days 5-6 days every day

In a typical week, how many times do you eat at, or take in from, FAST FOOD restaurants (i.e. Burger King, McDonald's, Carl's Junior)?

Never 1-2 times 3-4 times 5-6 times 7 or more times

In a typical week, how many times do you eat out at, or take in from, other restaurants?

Never 1-2 times 3-4 times 5-6 times 7 or more times

How often do you tend to "graze" (eat whenever the whim strikes)?

Never Sometimes Frequently

What are the times of day when you tend to "graze"? _____

Overall, how much do you like fruit?

A lot Somewhat Not much Not at all

Overall, how much do you like vegetables?

A lot Somewhat Not much Not at all

How much do you enjoy cooking?

A lot Somewhat Not much Not at all

How often do you watch TV while eating meals?

Often Sometimes Rarely Never

How often do you watch TV while snacking?

Often Sometimes Rarely Never

Have you ever been a vegetarian? No Yes, but for less than one month

Yes, for longer than one month

Are you a vegetarian now? Yes No If your answer is NO, skip the next 3 questions.

About how long have you been a vegetarian?

less than one month less than 1 year (but more than 1 month)
 1-2 years 3-4 years 5 years or more

As a vegetarian, do you eat any of the following?

	Yes	No
Eggs	<input type="checkbox"/>	<input type="checkbox"/>
Dairy food (such as milk, cheese)	<input type="checkbox"/>	<input type="checkbox"/>
Chicken	<input type="checkbox"/>	<input type="checkbox"/>
Fish	<input type="checkbox"/>	<input type="checkbox"/>

What are your main reason(s) for eating a vegetarian diet ? (Mark all that apply.)

to lose weight or keep from gaining weight
 want a healthier diet
 to help the environment
 religious reasons
 do not want to kill animals
 a family member is a vegetarian
 I don't like the taste of meat
 I don't like fat in meat
 other (please specify) _____

WHAT KIND OF PHYSICAL ACTIVITY DO YOU PARTICIPATE IN ?

To what extent do you enjoy physical activity?

Not at all Slightly Moderately Greatly

Do you have any physical problems that limit your physical activity?

Yes No If yes: please describe _____

In a usual week, how many hours do you spend doing the following activities :

Strenuous exercise (heart beats rapidly). Examples: biking fast, aerobic dancing, running, jogging, swimming laps, roller blading, tennis, cross country skiing, soccer, basketball, football.

None less than 1/2 hr a week 1/2-2 hrs a week
 2 1/2 - 4 hrs a week 4 1/2 - 6 hrs a week 6+ hrs a week

Moderate exercise (not exhausting). Examples: walking quickly, baseball, gymnastics, easy bicycling, volleyball, skiing, dancing, skateboarding, snowboarding.

none less than 1/2 hr a week 1/2-2 hrs a week
 2 1/2 - 4 hrs a week 4 1/2 - 6 hrs a week 6+ hrs a week

Mild exercise (little effort). Examples: Walking slowly (to do errands, to go to a friend's house, etc.), bowling, golf, fishing, yoga, strength training, Pilates.

none less than 1/2 hr a week 1/2-2 hrs a week
 2 1/2 - 4 hrs a week 4 1/2 - 6 hrs a week 6+ hrs a week

In your free time on an average weekday (Monday-Friday), how many hours do you spend...

	0 hr	1/2 hr	1 hr	2 hr	3 hr	4 hr	5+hr
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spending time on a computer or other electronic device	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

On an average weekend day (Saturday or Sunday), how many hours do you spend....

	0 hr	1/2 hr	1 hr	2 hr	3 hr	4 hr	5+hr
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spending time on a computer or other electronic device	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Approximately how many city blocks or the equivalent do you regularly walk each day?
 blocks (12 blocks equals 1 mile)

How many flights of stairs do you climb up each day? flights/day (let 1 flight equal 10 steps)

Please describe your daily lifestyle activity (i.e., how active you are) by picking any number from 1 to 10 with 1 = "very sedentary" and 10 = "very active."

Your number:

What factors decrease your ability to begin or maintain a fitness program? (check all that apply)

- Size
- Orthopedic issues/limitations
- Fatigue
- Difficulty in "getting myself there"
- I simply don't enjoy exercise
- I don't feel better after I exercise
- Time!
- Accessibility

SOMETIMES, OTHER THINGS GOING ON IN YOUR LIFE CAN AFFECT THE WAY YOU EAT

What do you typically do to relieve stress? _____

How often do you eat for emotional reasons (i.e. boredom, anxiety, frustration, sadness)?

- Often Sometimes Rarely Never

During the past 12 months, how often have you been bothered or troubled by....

	Not at all	Somewhat	Very Much
a. feeling too tired to do things	_____	_____	_____
b. having trouble going to sleep or staying asleep	_____	_____	_____
c. feeling unhappy, sad, or depressed	_____	_____	_____
d. feeling hopeless about the future	_____	_____	_____
e. feeling nervous or tense	_____	_____	_____
f. worrying too much about things	_____	_____	_____
g. changes in your appetite	_____	_____	_____
h. feeling angry or irritable with family or close friends	_____	_____	_____

Have you ever thought about killing yourself ?

- Yes, during the past year Yes, more than a year ago No

Has anyone ever abused you before...

- Emotionally or verbally ? Yes No Not sure
Sexually ? Yes No Not sure
Physically ? Yes No Not sure

To what extent do you feel that your weight has been an influential factor in the following domains:

	Not at all			To a large extent	
	1	2	3	4	5
Advancement in jobs (salary, promotions, recognition)	_____	_____	_____	_____	_____
Romantic/intimate relationships	_____	_____	_____	_____	_____
Making or sustaining friendships	_____	_____	_____	_____	_____
Casual interpersonal relationships (acquaintances, strangers, sales people)	_____	_____	_____	_____	_____

TOBACCO AND ALCOHOL USE:

Do you smoke cigarettes? ____ Yes, daily ____ Yes, occasionally ____ Yes, rarely ____ No

Have you ever experienced weight gain after cutting back or stopping smoking? ____ Yes ____ No

During the past year:

On average how many glasses per week did you have of each of the following:

wine ____ beer ____ hard liquor ____

What kinds of recreational drugs have you used in the past? _____

Which have you used in the past year? _____

WE WANT TO KNOW ABOUT YOUR PHYSICAL HEALTH

How would you describe your health? ____ poor ____ fair ____ good ____ excellent

Please indicate if you have had or have any of the medical conditions listed below:

	Yes	No
Diabetes (Type 1 or 2)	_____	_____
High cholesterol	_____	_____
Heart disease	_____	_____
Angina (chest pains)	_____	_____
Palpitations, fast or hard heartbeats	_____	_____
Stroke, mild stroke	_____	_____
Heart murmur	_____	_____
Rheumatic fever	_____	_____
Pacemaker	_____	_____
Breathing problems (asthma, lung disease)	_____	_____
High blood pressure	_____	_____
Anemia	_____	_____

	Yes	No
Back problems	_____	_____
Joint or bone problems	_____	_____
Arthritis	_____	_____
Hiatal hernia	_____	_____
Esophagitis, gastroesophageal reflux	_____	_____
Ulcers	_____	_____
Liver Disease	_____	_____
Gout (elevated uric acid)	_____	_____
Gallbladder disease, gallstones	_____	_____
Thyroid problems	_____	_____
Kidney disease	_____	_____
Sleep apnea	_____	_____
Other (specify)	_____	_____

FAMILY HISTORY

Please check all the biological relatives on either side of the family that currently have or have had these conditions in the past. If none, leave blank. MO = your Mother, FA = your Father, GM = Grandmother, GF = Grandfather, Other = Other relative (name relation).

	MOTHER'S SIDE				FATHER'S SIDE			
	MO	GM	GF	Other	FA	GM	GF	Other
Overweight	_____	_____	_____	_____	_____	_____	_____	_____
High cholesterol	_____	_____	_____	_____	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____	_____	_____
Heart attack	_____	_____	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____	_____	_____
Thyroid problem	_____	_____	_____	_____	_____	_____	_____	_____
Gallbladder problem	_____	_____	_____	_____	_____	_____	_____	_____
Polycystic ovaries	_____	_____	_____	_____	_____	_____	_____	_____
Eating disorder	_____	_____	_____	_____	_____	_____	_____	_____
Alcoholism	_____	_____	_____	_____	_____	_____	_____	_____
Depression	_____	_____	_____	_____	_____	_____	_____	_____
Learning Disabilities	_____	_____	_____	_____	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____	_____	_____	_____	_____
ADD/ADHD	_____	_____	_____	_____	_____	_____	_____	_____
Substance Abuse	_____	_____	_____	_____	_____	_____	_____	_____
Weight loss Surgery	_____	_____	_____	_____	_____	_____	_____	_____

Are there any other medical problems that run in the family? _____

Are there any other psychiatric problems that run in the family? _____

List all medications being taken (including vitamins and supplements). Please include the dosage and frequency of each medication. Medication/ Dosage/ Frequency/ Reason for Taking _____

Do you have allergies to any medications? ____ Yes ____ No

Foods? ____ Yes ____ No

Other allergies? ____ Yes ____ No

If female, do you experience a regular menstrual cycle? ____ Yes ____ No

If you checked "no ", can you describe what that means to you? _____

Are you currently using any birth control method? If so, which? _____

Place a check beside each symptom you have you experienced within the last six months:

- Blurry vision _____
- Headaches _____
- Nasal congestion/allergies _____
- Snoring _____
- Sleep apnea (pauses in breathing during sleep) _____
- Significant daytime sleepiness _____
- Dental caries/ cavities _____
- Acne _____
- Eczema (skin allergies) _____
- Excess hair growth on skin _____
- Darkening of the skin on the neck,
under the arms, or around the waist _____
- Always hot _____
- Always cold _____
- Paleness _____
- Chest pain _____
- Shortness of breath with exercise _____
- Stomach aches _____
- Vomiting _____

