Dear Valued Patient,

We are looking forward to meeting you as part of the initial evaluation at Chicago Weight.

In preparation for your visit we ask that you complete the following questionnaire. Please use **a different color font** for your answers.

Please email it back to us at [spannain@uchicago.edu](mailto:spannain@uchicago.edu) within 72 hours from receipt. Failure to do so may lead to rescheduling your visit.

Thank you so much for your cooperation and for trusting our care,

Best Regards

The Chicago Weight Team

Please write your name and Date of Birth:

Chicago Weight



**Health History Questionnaire**

**Background Information**

Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number and ages of children (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Hours: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (example 9 a.m. to 5 p.m.)

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Highest Level of Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been diagnosed with a learning problem (i.e., learning disability, dyslexia, etc.)? \_\_\_\_\_\_\_\_

Please list the people in your household and their relationships to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where were you born (city, state, country)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where were you raised (city, state, country)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who raised you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many siblings do you have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General Health Information**

How do you rate your health? \_\_\_\_\_ Poor \_\_\_\_\_ Fair \_\_\_\_\_ Good \_\_\_\_\_\_ Excellent

**Review of Systems (circle all that you currently have or have history of)**

**Respiratory**

Shortness of Breath Emphysema Disturbed Sleep

Coughing Snoring Sleep Apnea

Asthma or Wheezing Daytime Sleepiness History of Pneumonia,

Chronic Bronchitis or COPD

**Cardiovascular**

High Blood Pressure Irregular Heart Beat or Palpitations Ankle or Feet Swelling

Heart Disease/Heart Attack Blood Clots or Clotting Disorders Varicose Veins

Congestive Heart Failure Chest Pain or Discomfort Heart Murmur

**Genitourinary**

Difficulty Urinating Inability to empty bladder fully Sexual Problems

Urinary Incontinence (Leaking Urine) Recurrent urinary tract infections Infertility

Enlarged Prostate Abnormal Menstrual Periods

History of Kidney Stones

**Gastrointestinal**

Gastroparesis Heartburn Inflammatory bowel disease

Chronic constipation Irritable bowel disease History of weight loss surgery

**Musculoskeletal**

Aching muscles or joints Lower back pain/disc problems Arthritis Gout

**Endocrine**

Diabetes mellitus Thyroid Disease High triglycerides

High cholesterol Polycystic Ovarian Syndrome (PCOS)

**Skin and Hair**

Skin sores or infections (boils, ulcers, skin fold irritations) Bruises easily

Excessive facial/body hair (women only) Chronic rashes or dermatitis or eczema

**Other**

History of Glaucoma

Low energy level\_\_\_\_\_\_\_\_\_\_ Headaches Migraines

Cancer (list type): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other serious medical conditions (list types):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List the types of surgeries you have had:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mental Health**

Have you ever been evaluated for a mental health problem? Y N

If yes, have you ever been given a mental health diagnosis? Y N If yes, please list the diagnosis/diagnoses and approximate year they were given (for example, “depression in 1998, anxiety in 2001”): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been diagnosed with an eating disorder? Y N If yes, please specify the disorder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced child abuse, rape, or molestation? Y N NA (I elect not to answer)

Are you currently in mental health treatment? Y N If yes, please list the type(s) of treatment (i.e., therapy, medication, hypnosis, ECT, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you participated in mental health treatment in the past? Y N If yes, please list the type(s) of treatment (i.e., therapy, medication, hypnosis, ECT, etc.) and approximate time frame (for example, “Zoloft for depression 1998-2000, therapy for anxiety 2001-2002): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale from 1 (low stress), to 5 (high stress), how would you rate your daily stress level?

1 2 3 4 5

How do you cope with stress in your daily life?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Health Questionnaire (PHQ-9)**

*Over the last 2 weeks, how often have you been bothered by any of the following problems?*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | ***Not at all*** | ***Several days*** | ***More than half the days*** | ***Nearly every day*** |
| 1. Little interest or pleasure in doing things |  |  |  |  |
| 1. Feeling down, depressed, or hopeless |  |  |  |  |
| 1. Trouble falling or staying asleep, or sleeping too much |  |  |  |  |
| 1. Feeling tired or having little energy |  |  |  |  |
| 1. Poor appetite or overeating |  |  |  |  |
| 1. Feeling bad about yourself…. Or that you are a failure or have let yourself or your family down |  |  |  |  |
| 1. Trouble concentrating on things, such as reading the newspaper or watching television |  |  |  |  |
| 1. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual |  |  |  |  |
| 1. Thoughts that you would be better off dead, or of hurting yourself |  |  |  |  |

1. If you have experienced any of the problems above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

|  |  |
| --- | --- |
| *Not difficult at all* |  |
| *Somewhat difficult* |  |
| *Very difficult* |  |
| *Extremely difficult* |  |

**Family History**

Do you have a family history of any of the following? (circle all that apply)

High blood pressure High blood cholesterol Diabetes Thyroid Disease

Obesity Heart disease Cancer, if yes please specify

Mental Health Problems Alcohol or Substance Abuse Other (list):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social history**

Do you use any tobacco products? Y N if yes, please circle the type(s):

Cigarettes Cigars Pipe Snuff/chewing tobacco Other: \_\_\_\_\_\_\_\_\_\_

How much tobacco do you use/smoke per day? \_\_\_\_ or per week? \_\_\_\_\_ or per month? \_\_\_\_\_\_

If you used tobacco products in the past, when did you quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink any alcohol? Y N

If yes: how many alcoholic drinks per day? \_\_\_\_or per week? \_\_\_\_or per month? \_\_\_\_

**Sleep History**

*The following questions relate to your usual sleep habits* ***during the past month*** *only. Your answers should*

*indicate the most accurate reply for the majority of days and nights in the past month.*

1. During the past month, when have you usually gone to bed?

Usual WORKDAY Bed Time \_\_\_\_\_\_\_\_\_\_\_\_ Usual NON-WORKDAY Bed Time \_\_\_\_\_\_\_\_\_\_\_\_

2. During the past month, how long (in minutes) has it usually taken you to fall asleep?

NUMBER OF MINUTES \_\_\_\_\_\_\_\_\_\_\_\_

3. During the past month, when have you usually gotten up?

Usual WEEKDAY Getting Up Time \_\_\_\_\_\_\_\_\_\_\_\_ Usual WEEKEND Getting Up Time \_\_\_\_\_\_\_\_\_\_\_\_

4a. During the past month, how many hours of actual sleep did you get at night on weekdays and weekends? (This may be different than the number of hours you spend in bed)

WORKDAY Hours of Sleep per Night \_\_\_\_\_\_\_\_\_\_\_ NON-WORKDAY Hours of Sleep per Night \_\_\_\_\_\_\_\_\_\_\_\_

4b. If you could regularly get as much sleep as you wanted in one night, how much sleep would you prefer to

get? HOURS OF SLEEP PER NIGHT \_\_\_\_\_\_\_\_\_\_\_

During the past month, how would you rate your sleep quality overall?

Very Good Fairly Good Fairly Bad Very Bad

Is your sleep restful? Yes No

Do you have a bed partner or roommate? Yes No

Have you been told you snore loud? Y N

Has anyone noticed that you stop breathing during your sleep? Y N

***Epworth Sleepiness Scale***

*How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you.*

*Use the following scale to choose the* ***most appropriate number*** *for each situation:*

***0*** *= would* ***never*** *doze*

***1*** *=* ***slight chance*** *of dozing*

***2*** *=* ***moderate*** *chance of dozing*

***3*** *=* ***high chance*** *of dozing*

***Situation Chance of Dozing (0-3)***

*1. Sitting and reading ........................................................................................*

*2. Watching TV ..................................................................................................*

*3. Sitting inactive in a public place (e.g. a theatre or a meeting) ....................*

*4. As a passenger in a car for an hour without a break ...................................*

*5. Lying down to rest in the afternoon when circumstances permit ...............*

*6. Sitting and talking to someone .....................................................................*

*7. Sitting quietly after a lunch without alcohol ................................................*

*8. In a car, while stopped for a few minutes in traffic .....................................*

**Weight Loss Information**

What is your reason for seeking treatment at this time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What has been your lowest body weight as an adult? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What has been your heaviest body weight as an adult? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you start to gain weight? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any notable life/health event associated with your weight gain (such as college, pregnancy, marriage, divorce, death in the family, new health condition or treatment which may have affected your weight)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past weight loss programs/treatments:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Program/Treatment Name** | **# of times?** | **When?** | **How long in program?** | **Amt. of weight loss** | **How long kept weight off?** | **Pros and cons of program/**  **treatment for you?** |
| Weight Watchers |  |  |  |  |  |  |
| Medi-Fast |  |  |  |  |  |  |
| Medi-Weight Loss |  |  |  |  |  |  |
| Jenny Craig |  |  |  |  |  |  |
| NutriSystem |  |  |  |  |  |  |
| L.A. Weight Loss |  |  |  |  |  |  |
| Herbal Life |  |  |  |  |  |  |
| Weight loss research study |  |  |  |  |  |  |
| Atkins |  |  |  |  |  |  |
| South Beach |  |  |  |  |  |  |
| Dietician/nutritionist |  |  |  |  |  |  |
| Bariatric surgery |  |  |  |  |  |  |
| Personal trainer |  |  |  |  |  |  |
| Dieting on your own |  |  |  |  |  |  |
| Exercising on your own |  |  |  |  |  |  |
| Other weight loss program: |  |  |  |  |  |  |
| Orlistat/Xenical |  |  |  |  |  |  |
| Meridia |  |  |  |  |  |  |
| Alli |  |  |  |  |  |  |
| Phentermine/Adipex |  |  |  |  |  |  |
| Fen-Phen |  |  |  |  |  |  |
| Belviq |  |  |  |  |  |  |
| Qsymia |  |  |  |  |  |  |
| Contrave |  |  |  |  |  |  |
| Saxenda |  |  |  |  |  |  |
| Over the counter weight loss products  Name |  |  |  |  |  |  |
| Over the counter weight loss products  Name |  |  |  |  |  |  |
| Over the counter weight loss products  Name |  |  |  |  |  |  |

What is your:

1. Ideal weight: \_\_\_\_\_\_\_\_
2. Happy weight: \_\_\_\_\_\_\_\_
3. Acceptable weight: \_\_\_\_\_\_\_\_
4. Unacceptable weight: \_\_\_\_\_\_\_\_

What makes it hard for you to lose weight and keep it off? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of 1 (not ready) to 5 (very ready), how ready are you to make lifestyle changes to lose weight at this time?

1 2 3 4 5

On a scale of 1 (not confident) to 5 (very confident), how confident are you in losing weight at this time?

1 2 3 4 5

**Nutrition Information**

In your opinion, which of the following contributes to your excess weight? Please circle which apply.

Larger than normal portions

High fat food choices

High sugar food choices

Sugary beverages

if **yes** please specify type and amount of **sugary beverages**, including alcoholic drinks as they contain sugar

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lack of knowledge in healthy eating

Lack of time for meal preparation

Meal skipping

Emotional eating/Stress eating

Lack of exercise

Medications

Other:

How willing are you to make changes in your diet? On a scale from 1-5 with 5 being the most willing, please assign a number.

1 2 3 4 5

How confident are you that you can make successful changes to your diet? On a scale from 1-5 with 5 being the most confident, please assign a number.

1 2 3 4 5

Are you interested in learning about:

-Dietary education Yes No Maybe

-Exercise education Yes No Maybe

-Weight loss medications Yes No Maybe

-Meal replacements with Optifast Yes No Maybe

-Weight loss surgery Yes No Maybe

-Endoscopic sleeve/other procedure: Yes No Maybe

Please describe some of your personal barriers to eating healthy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any religious practices that affect your health care or diet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Eating Questionnaire**

Please carefully complete all questions, choosing NO or 0 for questions that do not apply.

1. During the past 3 months have there been times when you have eaten what other people would regard as an unusually large amount of food (e.g., a pint of ice cream) given the circumstances?

[ ] YES

[ ] NO

1. During the times when you ate an unusually large amount of food, did you experience a loss of control (e.g., felt you couldn't stop eating or control what or how much you were eating)?

[ ] YES

[ ] NO

1. How many times per month on average over the past 3 months have you eaten an unusually large amount of food and experienced a loss of control?

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+

# **During episodes of overeating with a loss of control, did you…**

1. Eat much more rapidly than normal?

[ ] YES

[ ] NO

1. Eat until you felt uncomfortably full?

[ ] YES

[ ] NO

1. Eat large amounts of food when you didn't feel physically hungry?

[ ] YES

[ ] NO

1. Eat alone because you were embarrassed by how much you were eating?

[ ] YES

[ ] NO

1. Feel disgusted with yourself, depressed, or very guilty after overeating?

[ ] YES

[ ] NO

1. If you have episodes of uncontrollable overeating, does it make you very upset?

[ ] YES

[ ] NO

In order to prevent weight gain or counteract the effects of eating, how many times per month on average over the past 3 months have you:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16+ |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16+ |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16+ |

1. Made yourself vomit?
2. Used laxatives or diuretics?
3. Fasted (skipped at least 2 meals in a row)?

**Over the past 3 months…**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Not at all** | | **Slightly** | | **Moderately** | | **Extremely** | | |
| 0 | 1 | | 2 | 3 | 4 | | 5 | 6 |
|  |  | |  |  |  | |  |  |
|  |  | |  |  |  | |  |  |
|  |  | |  |  |  | |  |  |
| 0 | 1 | | 2 | 3 | 4 | | 5 | 6 |

1. Has your weight or shape influenced how you judge yourself as a person?
2. How much do eating or body image problems impact your relationships with friends and family, work performance, and school performance?

Do you obtain second helpings?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you sometimes eat when not hungry? How often?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In a given week, how many times do you eat food not prepared by you or a family member?  (i.e. from cafeteria, restaurant, coworker, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide specific details regarding your diet this past month. Please in the charts below log your food intake for 2 consecutive week days and 1 weekend day. Provide food items and amounts. Instead of writing "sandwich,” describe the sandwich. For example: 2 slices rye bread, 3 slices turkey, smear of mayo and mustard, lettuce, tomato.

**PLEASE INCLUDE THE TIME (second column)!** Write “None” if you did not eat that meal or snack

**Weekday # 1**

|  |  |  |  |
| --- | --- | --- | --- |
| **Meal (include drinks)** | **Time** | **Food eaten** | **Amount** |
| Breakfast |  |  |  |
| Snack |  |  |  |
| Lunch |  |  |  |
| Snack |  |  |  |
| Dinner |  |  |  |
| Snack |  |  |  |
| Any additional food/drink intake beside meals/snacks above |  |  |  |

**Weekday # 2**

|  |  |  |  |
| --- | --- | --- | --- |
| **Meal (include drinks)** | **Time** | **Food eaten** | **Amount** |
| Breakfast |  |  |  |
| Snack |  |  |  |
| Lunch |  |  |  |
| Snack |  |  |  |
| Dinner |  |  |  |
| Snack |  |  |  |
| Any additional food/drink intake beside meals/snacks above |  |  |  |

**One Weekend day**

|  |  |  |  |
| --- | --- | --- | --- |
| **Meal (include drinks)** | **Time** | **Food eaten** | **Amount** |
| Breakfast |  |  |  |
| Snack |  |  |  |
| Lunch |  |  |  |
| Snack |  |  |  |
| Dinner |  |  |  |
| Snack |  |  |  |
| Any additional food/drink intake beside meals/snacks above |  |  |  |

**Physical Activity Information**

What is the most physically active thing you do in an average day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What, if any, regular exercise do you do? How often and for how long do you participate? \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is or would be your preferred exercise?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you know of any reason(s) why you should not do physical activity? If yes, please explain. \_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What gets in the way of you consistently engaging in physical activity/exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours of television do you watch every day? (circle one)

<1 hour (minimal) 1-2 hours 3-4 hours over 5 hours

Do you have a sedentary job (if applicable)? Y N

On a scale of 1 (not ready) to 5 (very ready), how ready are you to begin exercising?

1 2 3 4 5

On a scale of 1 (not confident) to 5 (very confident), how confident are you in engaging in physical activity?

1 2 3 4 5

****

Chicago Weight

**DEBQ- EE scale**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | (1)  never | (2) seldom | (3) sometimes | (4)  often | (5)  very often |
| 1. Do you have the desire to eat when you are irritated? |  |  |  |  |  |
|  |  |  |  |  |  |
| 1. Do you have a desire to eat when you have nothing to do? |  |  |  |  |  |
|  |  |  |  |  |  |
| 1. Do you have a desire to eat when you are depressed or discouraged? |  |  |  |  |  |
|  |  |  |  |  |  |
| 1. Do you have a desire to eat when you are feeling lonely? |  |  |  |  |  |
|  |  |  |  |  |  |
| 1. Do you have a desire to eat when somebody lets you down? |  |  |  |  |  |
|  |  |  |  |  |  |
| 1. Do you have a desire to eat when you are cross/angry? |  |  |  |  |  |
|  |  |  |  |  |  |
| 1. Do you have a desire to eat when you are expecting something unpleasant to happen? |  |  |  |  |  |
|  |  |  |  |  |  |
| 1. Do you have the desire to eat when you are anxious, worried, or tense? |  |  |  |  |  |
|  |  |  |  |  |  |
| 1. Do you have a desire to eat when things are going against you or when things have gone wrong? |  |  |  |  |  |
|  |  |  |  |  |  |
| 1. Do you have a desire to eat when you are frightened? |  |  |  |  |  |
|  |  |  |  |  |  |
| 1. Do you have a desire to eat when you are disappointed? |  |  |  |  |  |
|  |  |  |  |  |  |
| 1. Do you have a desire to eat when you are emotionally upset? |  |  |  |  |  |
|  |  |  |  |  |  |
| 1. Do you have a desire to eat when you are bored or restless? |  |  |  |  |  |