WEIGHT & METABOLIC SOLUTIONS AUSTRALIA

The Future Is Already - To Your Health. Always.

PRE-SURGICAL EVALUATION QUESTIONNAIRE - Return MAXIMUM 10 days after initial visit

This questionnaire is designed to obtain information about your;
- Weight and dieting history
- Eating and exercise habits
- Relationships with family, friends and colleagues

Each of these plays a critical role in understanding YOU and planning for your future.

Please complete the questionnaire carefully, in an open and honest fashion, making your best guess if you're not completely sure. Feel free to use the margins and bottom of pages when you need more space for your answers. When it is required, please circle the appropriate answers. Please complete this questionnaire in a BLACK pen.
(Highlighter, blue pen and pencil is not recognised by our software)

You will have an opportunity to review your answers with a member of our multi-disciplinary team.

Please allow sufficient time to complete this questionnaire. Your answers will help us better

(A) Demographic Details

Title: Mr / Mrs/ Miss/ Ms/ Dr	Date of Birth & Age:
First & Middle Name	Surname:
Home Address:	Suburb & Postcode
Mobile No:	Email:
Home No:	Work No:
Occupation	NOK Relationship to you:
Next of Kin:	NOK Contact Number:

We may share this information with health providers that have previously treated you or may treat you in the future. (i.e. General Practitioner, Specialist, Psychiatrist, Psychologist)

By signing below you give consenting of sharing this information with such parties.

Name: _____ Sign: _____

(B) SOCIAL PROFILE

FAMILY DEMOGRAPHICS:

☐ Married
☐ Single
☐ Divorced
☐ Separated
☐ Widowed
☐ Partner/ Relationship

Child Name: Gender: Age or □ Not Applicable

_____
_____
_____
_____
_____
_____

Currently I am (tick all that apply):

☐ Living alone
☐ Living with a spouse or partner
☐ Living with a significant other
☐ Living with parents or step-parents
☐ Living with other relatives
☐ Living with roommates
☐ Living with children

1) Please indicate the total number of persons living in your home _____

2) If you are currently involved in an intimate relationship, please answer these questions:

a) What is this person's attitude towards your efforts to lose weight

☐ Strongly supports my efforts ☐ Neutral ☐ Opposes my efforts
☐ Supports my efforts ☐ Strongly opposes my efforts

b) Please briefly describe what this person does to help or hinder your weight loss efforts:

_____
_____

c) Overall, how satisfied are you with your relationship with this person?

☐ Very satisfied ☐ Neutral ☐ Dissatisfied
☐ Satisfied ☐ Very Dissatisfied

3) Will other people support your weight loss effort? ☐ Yes ☐ No

If Yes, Who? _____

4) How many are actively helping you?

_____

5) How many people do you speak with about your weight when it upsets you?

_____

6) How many of these people are helpful to you?

_____

7) Will other people oppose or undermine your weight loss effort? ☐ Yes ☐ No

If Yes, Who? _____

8) Who are you support persons & friends:

_____
_____
_____
_____

EMPLOYMENT:
Are you currently employed or retired?

Are you full time, part time or casual?

If you are unemployed, what is the reason?

Are you actively looking for work?

Has your weight made it difficult to find employment?

If you are employed please select which level of activity your job involves:
☐ Little (Sedentary) ☐ Moderately Active ☐ Very active (i.e. Labouring)

(C) MEDICAL AND SURGICAL HISTORY

PAST MEDICAL HISTORY:

Please Identify which of the following childhood illnesses you have experienced:

□ Measles	□ Heart Murmur	□ Obesity
□ Rheumatic Fever	□ Chickenpox	□ Tonsillectomy
□ Mumps	□ Asthma	

Have you ever suffered any of the following health problems?

Kidney or Urinary Disorder: ☐ No ☐ Yes _____
Neurological: ☐ No ☐ Yes _____
Psychological/Nervous: ☐ No ☐ Yes _____
Gastric or Duodenal Ulcer: ☐ No ☐ Yes _____
Hepatitis or Liver Disease: ☐ No ☐ Yes _____
Anaemia or Bleeding Disorder: ☐ No ☐ Yes _____
Thrombosis or Clotting Disorder: ☐ No ☐ Yes _____
Eczema or Skin Condition: ☐ No ☐ Yes _____
Hay Fever or Rhinitis: ☐ No ☐ Yes _____
Thyroid Disease: ☐ No ☐ Yes _____
Osteoporosis: ☐ No ☐ Yes _____
AIDS/HIV Exposure: ☐ No ☐ Yes _____

Please give details of any other major illnesses or problems:

SURGICAL HISTORY:

Please give details of any past operations:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

MEDICATIONS:
Please list all medications including; eye drops, creams, dietary supplements, multivitamins, herbal remedies, and over the counter medications:

Please indicate whether you are now or have previously taken any of the following medications. If yes, please state the name of the medication and the duration of you taking it.

Medication for a psychiatric disorder: ☐ No ☐ Yes _____
Medication for epilepsy: ☐ No ☐ Yes _____
Hormones or Contraceptive Pill: ☐ No ☐ Yes _____
Cortisone: ☐ No ☐ Yes _____

Name of Medication	Dose	Time(s) Take	Reason

ALLERGIES:

Do you have an allergy to:

Surgical Tape: ☐ No ☐ Yes **Latex:** ☐ No ☐ Yes **Iodine:** ☐ No ☐ Yes

Do you have any allergies (including food, medication, dressings): ☐ No ☐ Yes

_____
_____
_____
_____

SUBSTANCE USE HISTORY:

ALCOHOL:

How often do you have an alcoholic beverage?

☐*Never* ☐ *Monthly or less* ☐ *2-4 a month* ☐ *2-3 a week* ☐ *4 or more a week*

How many standard drinks do you have on a normal day?

☐*Nil* ☐ *1-2* ☐ *3-4* ☐ *5-6* ☐ *7-9* ☐ *10 or more*

How often do you have more than 6 standard drinks on one occasion?

☐*Never* ☐ *Less than monthly* ☐ *Monthly* ☐ *Weekly* ☐ *Daily or thereabouts*

SMOKING:

Do you smoke? ☐ Yes ☐ No *If yes, how many per day?*_____

Have you smoked in the past? ☐ Yes ☐ No

*If yes, how many per day?*_____ *For how many years?*_____

When did you quit? _____ *Why?* _____

ILLICIT DRUGS:

Do you use any illicit drugs? ☐ Yes ☐ No

If yes, please provide details: _____

Have you used illicit drugs in the past? ☐ Yes ☐ No

If yes, please provide details: _____

Female Patients ONLY:

Irregular Periods ☐ Yes ☐ No

Excessively Heavy Periods ☐ Yes ☐ No

Difficulty Conceiving ☐ Yes ☐ No

Excess Body Hair or Acne ☐ Yes ☐ No

Polycystic Ovaries ☐ Yes ☐ No

Number of Pregnancies: _____

Number of Live Births: _____

Miscarriage/ Abortions: _____

Obstetric Complications: _____

FAMILY MEDICAL HISTORY:

Do you have a family history of the following, if so, please indicate:

Illness	Parent	Siblings or Child	Other Relatives (Cousins, Aunts, Grandparents)	No History	Unsure
Obesity					
Diabetes					
Heart Disease					
Hypertension					
Gout					
Gallstones					
Snoring/Sleep Apnoea					
Asthma					
Hayfever					
High Cholesterol					
Osteoporosis					
Hip Fractures					
Breast Cancer					
Colon Cancer					

(D) WEIGHT RELATED ILLNESSES

Have you ***ever suffered*** with any of the following health problems?

Heart Disease:

☐ No ☐ Yes *If Yes, Year Diagnosed* _____

Do you have or have you had:

☐ *Angina* ☐*CABG (Coronary Artery Bypass Graft)* ☐*MI (Myocardial Infarction)*

☐ *Stress test to rule out cardiac problems* ☐*Abnormal ECG* ☐*Palpitations*

High Cholesterol:

☐ No ☐ Yes *If Yes, Year Diagnosed* _____

High Triglycerides:

☐ No ☐ Yes *If Yes, Year Diagnosed* _____

Diabetes *OR* **Impaired Glucose Tolerance:**

☐ No ☐ Yes *If Yes, Year Diagnosed* _____

Juvenile Onset: ☐ No ☐ Yes
Whilst Pregnant: ☐ No ☐ Yes
Neuropathy: ☐ No ☐ Yes
Controlled with:
☐Diet
☐ Oral Medications _____
☐ Insulin _____
☐ Current Blood Sugar Level (BSL) _____

Asthma:

☐ No ☐ Yes *If Yes, Year Diagnosed* _____

Hospitalisation last 2 years: ☐ No ☐ Yes
Steroids last 2 years: ☐ No ☐ Yes

Cough & Shortness of Breath:

☐ No ☐ Yes

*Do you usually bring up **phlegm** from your chest when you cough?:* ☐ No ☐ Yes
Do you get *shortness of breath on exertion of force?:* ☐ No ☐ Yes
Do you get *shortness of breath walking on a flat surface?:* ☐ No ☐ Yes
Do you get *shortness of breath walking up hill?:* ☐ No ☐ Yes
Do you get *shortness of breath doing house work?:* ☐ No ☐ Yes

How many blocks can you walk*?:* _____
How many flights of stairs can you climb*?:* _____

Trouble Sleeping:

☐ No ☐ Yes *If Yes, Year Diagnosed* _____

Do you use a C-PAP machine: ☐ No ☐ Yes *If Yes: Pressure* _____ *cmH2O*

Please answer each question, mark the line with a cross (**X**) in the position best indicating your answer.

How often do you **snore**?

NEVER _____ ALWAYS

Do you wake up during the night with a **choking feeling or gasping**?

NEVER _____ ALWAYS

How often do you **sleep more than 8 hours** in total in a 24 hour period?

NEVER _____ ALWAYS

How often do you **wake up** more than once **during the night**?

NEVER _____ ALWAYS

Do you have a **headache when you wake up** in the morning?

NEVER _____ ALWAYS

Have you noticed a **reduction** in your **libido or sex drive**?

NEVER _____ ALWAYS

Do you feel **sleepy during the day?**

NEVER _____ ALWAYS

Has anyone noticed that you **momentarily stop breathing** during your sleep?

NEVER _____ ALWAYS

Do you fall asleep **while reading**?

NEVER _____ ALWAYS

Do you wake up in the morning **feeling confused**?

NEVER _____ ALWAYS

How often do you have a **nap** during the day?

NEVER _____ ALWAYS

Do you feel **sleepy in the evenings**?

NEVER _____ ALWAYS

Have you or anyone else noticed a **change in your personality** recently?

NEVER _____ ALWAYS

How often do you **doze off** or fall asleep while **driving**?

NEVER _____ ALWAYS

How often do you **doze off** or fall asleep when **at work or school**?

NEVER _____ ALWAYS

How often do you **doze off** or fall asleep when **watching TV**?

NEVER _____ ALWAYS

How often do you **doze off** or fall asleep when sitting, **inactive in a public place** (e.g. theatre, meeting)?

NEVER _____ ALWAYS

How often do you **doze off** or fall asleep as a **passenger in a car** for an hour without a break?

NEVER _____ ALWAYS

How often do you **doze off** or fall asleep when **lying down to rest** in the afternoon when circumstances permit?

NEVER _____ ALWAYS

How often do you **doze off** or fall asleep when **sitting and talking** to someone?

NEVER _____ ALWAYS

How often do you **doze off** or fall asleep when **sitting quietly after a lunch** without alcohol?

NEVER _____ ALWAYS

If your sleep is a major problem to you or your partner, would you be prepared to have a sleep study performed now and after you lose weight? □ Yes □ No

Gallbladder Disease:

☐ No ☐ Yes *If Yes, Year Diagnosed* _____

Leakage of Urine with Laughing/Coughing/Sneezing: ☐ No ☐ Yes

If Yes, Do you wear pads frequently? ☐ No ☐ Yes

Low Back Strain/ Pain/ Sciatica:

☐ No ☐ Yes *If Yes, please give details* _____

Joint Pain in Hips/ Knees/ Ankles/ Feet:

☐ No ☐ Yes *If Yes, please give details* _____

Weight Related Injuries & Trauma:

☐ No ☐ Yes *If Yes, please give details* _____

Varicose Veins or Leg Swelling: ☐ No ☐ Yes

If Yes, Please answer the following:

Scaly & Thick Skin: ☐ No ☐ Yes

Leg Ulcers: ☐ No ☐ Yes

Gastro-oesophageal Reflux/ Indigestion: ☐ No ☐ Yes

If Yes, how often ☐ *Multiple Times Daily* ☐ *Everyday* ☐ *Most Days* ☐*Occasionally*

Do you suffer **heart burn/ indigestion** during the night? ☐ No ☐ Yes

If Yes, how often ☐ *Multiple Times Nightly* ☐ *Every night* ☐ *Most Nights* ☐*Occasionally*

What aggravates or causes your reflux?

_____

Do you have difficulties **swallowing**?

☐ No ☐ Yes *If Yes, please give details* _____

Does **food** ever **get stuck?**

☐ No ☐ Yes *If Yes, please give details* _____

Does food or fluid **reflux** into the mouth?
☐ No ☐ Yes *If Yes, please give details* _____

Do you **vomit** with reflux?
☐ No ☐ Yes *If Yes, please give details* _____

Do you suffer from recurrent **sore throats**?
☐ No ☐ Yes *If Yes, please give details* _____

Do you suffer from a **hoarse voice**?
☐ No ☐ Yes *If Yes, please give details* _____

Do you suffer from a regular **cough at night?**
☐ No ☐ Yes *If Yes, please give details* _____

Please list any treatments you may use for reflux, heartburn or indigestion:

_____
_____
_____

(E) WEIGHT HISTORY

Height: Current Weight:	Current BMI:
Goal Weight:	Goal BMI:

Tick the statement that best describes you**: "During the past 6 months my weight has…"**

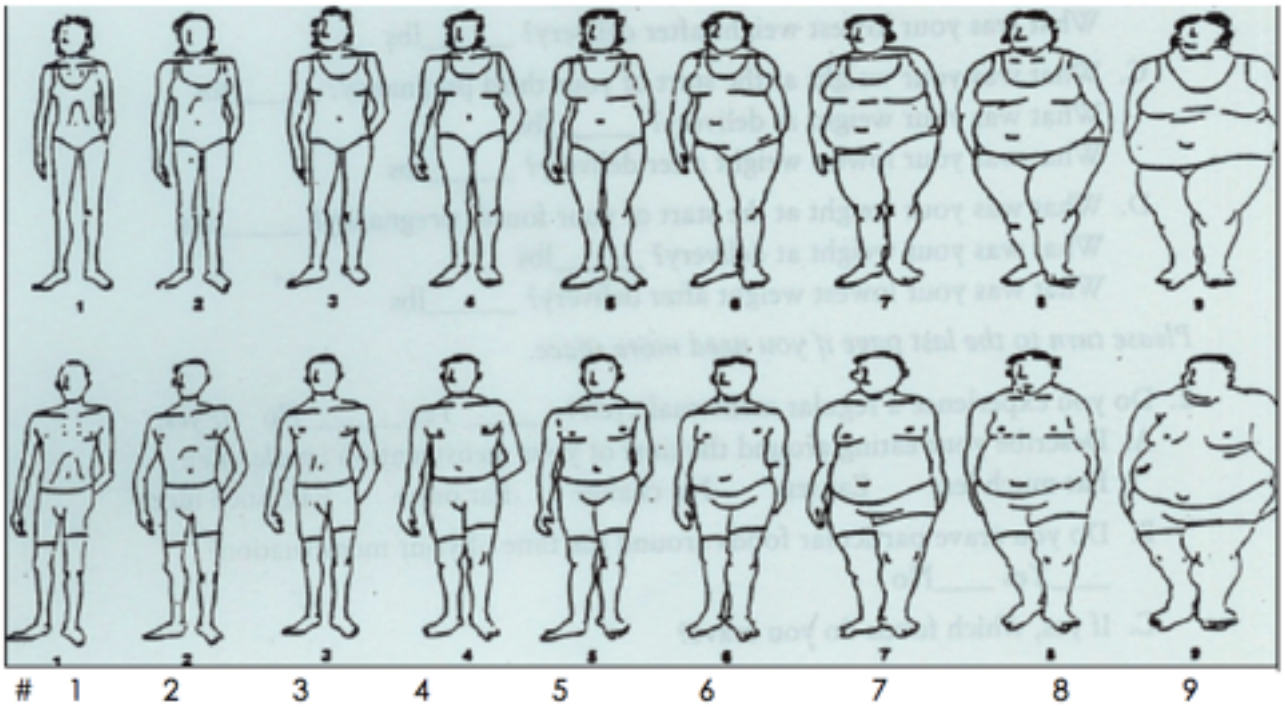
☐ Decreased more than 10kg ☐ Increased by more than 10kg

☐ Decreased by 5-10kg ☐ Increased by 5-10kg

☐ Remained relatively stable

Please estimate your weight as closely as possible for all that applies.
Please also indicate whether you consider your weight was *below average, average, above average or very heavy* in the relevant boxes. Please *identify the figure* that most resembles yours at that time (*see graph below, larger scale p.12*).
Record the number of the figure.

Life Event	Estimated Weight	Below Average	Average	Above Average	Very Heavy	Figure No.
Birth Weight						
Start of School (5-6 Years)						
Start of High School (10-12 Years)						
High School Graduation (16-18 Years)						
Commencing Work						
Marriage (_____ Years)						
Lowest weight in past 5 years						
Highest weight in past 5 years						
Other _____						
Other _____						



FOR FEMALE PATIENTS ONLY:

Please estimate your weight as closely as possible for all that applies.
Please also indicate whether you consider your weight was *below average, average, above average or very heavy* in the relevant boxes. Please *identify the figure* that most resembles yours at that time (*see graph on previous page*).
Record the number of the figure.

Pregnancy	Year	Weight at Start	Weight at Delivery	Figure
1				
2				
3				
4				

(F) WEIGHT LOSS HISTORY

PAST ATTEMPTS

1) Please record each major weight loss (i.e. diet, exercise, moderation, etc.) that resulted in a weight loss of 5 kg or more.

☐ Weight Watchers: Duration: _____ Weight Lost: _____
☐ Gloria Marshall: Duration: _____ Weight Lost: _____
☐ Jenny Craig: Duration: _____ Weight Lost: _____
☐ Tony Ferguson: Duration: _____ Weight Lost: _____
☐ Nutrisystem: Duration: _____ Weight Lost: _____
☐ Other: _____ Duration: _____ Weight Lost: _____
☐ Hypnoetherapy: Duration: _____ Weight Lost: _____
☐ Food Diet: Duration: _____ Weight Lost: _____
☐ Appetite Suppressant (Duromine) Duration: _____ Weight Lost: _____
☐ Drug Treatment (Reductil, Xenicol) Duration: _____ Weight Lost: _____

Take time to think over your previous efforts, starting with the first one, whether in childhood or adulthood. You may have difficulty remembering this information at first, but most people can if they take their time:

2) Details of any other weight loss measures (including surgical):

_____

_____

3) Was there any particular event that lead to significant weight gain?

_____

_____

4) Pick any number from 1 to 10 to indicate below how accurate you think you were in remembering and recording your weight loss history
1 is **"not at all accurate"** and **10** is **"completely accurate."** Your number is _____

5) In the past year, how many times have you started a weight loss program on your own that lasted for more than 3 days? _____ times.

6) In the past year, how many times have you started a weight loss program that lasted for 3 days or less? _____ times.

7) Have you ever experienced any significant physical or emotional symptoms while attempting to lose weight or after losing weight? ☐ No ☐ Yes

If Yes, please describe your symptoms, how long they lasted, and the type of professional help sought, if any:

_____
_____
_____

(G) WEIGHT LOSS GOALS

1) How much weight would you like to lose _____

2) This would bring you down to a body weight of _____

3) When did you last weigh this amount _____

4) About how long was this weight maintained _____

5) Was it achieved after a weight loss effort ☐ No ☐ Yes

6) If you are successful in this program, in changing your eating and exercise habits, how much weight do you realistically expect to lose after;

1 month _____
3 months _____
6 months _____
12 months _____

7) In your own words, please describe what you hope to accomplish and how you believe your life will change by losing weight

_____
_____
_____
_____
_____
_____

(H) FOOD PREFERENCES & EATING BEHAVIOURS

Please indicate the degree to which you believe each of the following behaviours causes you to gain weight. In answering these questions, please use the 5-point scale below. Pick the one number that best describes how much the behaviour contributes to your increased weight:

1 *= Does not contribute at all*
2 *= Contributes a small amount*
3 *= Contributes a moderate amount*
4 *= Contributes a large amount*
5 *= Contributes the greatest amount*

Contributing Behaviour	**Score 1-5**
Eating too much food	
Overeating at breakfast	
Overeating at lunch	
Overeating at dinner	
Snacking between meals	
Snacking after dinner	
Eating because I feel physically hungry	
Eating because I crave certain foods	
Continuing to eat because I don't feel full after a meal	
Eating because I can't stop once I've begun	
Eating because of the good taste of foods	
Eating in response to the sight or smell of food	
Eating while cooking or preparing food	
Eating when anxious	
Eating when tired	
Eating when bored	
Eating when stressed	
Eating when depressed/upset	
Eating when socialising/celebrating	
Eating when happy	
Eating when alone	
Eating with family/friends	
Eating at business functions	

1) Please indicate any other factors that contribute a moderate amount or more to your weight gain:

_____

_____

2) How many days a week do you eat the following meals?
Write the number of days and the usual time of the meal in the spaces:

a) Breakfast _____ Days _____ Time
b) Morning Snack _____ Days _____ Time
c) Lunch _____ Days _____ Time
d) Afternoon Snack _____ Days _____ Time
e) Dinner _____ Days _____ Time
f) Evening Snack _____ Days _____ Time

3) Who prepares meals at your home? _____

4) Who does the food shopping? _____

5) Please list your five (5) favourite foods:

1) _____
2) _____
3) _____
4) _____
5) _____

6) Please specify the amount (in cup/glass) of the following fluids you consume daily:

Fluid	No. Cups/ Glasses	Fluid	No. Cups/ Glasses
Skim Milk		Wine	
Low Fat Milk		Spirits	
Whole Milk		Water	
Mineral Water		Diet Soft Drink	
Fruit Juice		Sugar Soft Drink	
Tea		Beer	
Coffee		Other	
Other		Other	

7) During a typical week, how many meals do you eat at a fast-food restaurant *(including drive-thru and convenience stores)*

Breakfast _____ Days
Lunch _____ Days
Dinner _____ Days

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

Breakfast _____ Days
Lunch _____ Days
Dinner _____ Days

9) How many times a week do you typically eat out with others (including family)

_____ *Days*

10) Indicate which food you prefer (the foods most likely to make you deviate from a diet)
Rank each selection from **1 - very likely** to **4 - do not care**

Soft Drink		Fried Foods		Cakes/ Pies		Salad Dressing	
Steak/ Chops		Chips/ Snacks		French Fries			
Chocolate		Lollies		Potatoes			
Pizza		Pasta		Cookies			

FOR FEMALE PATIENTS ONLY:

11) Describe your eating around the time of your menstruation (tick one):

☐ Eat much less
☐ Eat less
☐ No Change
☐ Eat more
☐ Eat much more

12) Do you crave particular foods around the time of menstruation? ☐ No ☐ Yes

If Yes, which foods do you crave?

_____
_____

(I) FOOD INTAKE RECALL

Please indicate the foods you consume on a typical ***weekday***

Meal	Time	Location	Food & Beverages Consumed	Amount
Breakfast				
Morning Snack				
Lunch				
Afternoon Snack				
Dinner				
Evening Snack				

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

Meal	Time	Location	Food & Beverages Consumed	Amount
Breakfast				
Morning Snack				
Lunch				
Afternoon Snack				
Dinner				
Evening Snack				

(J) EATING & WEIGHT PATTERNS

1) During the past 6 months, did you often eat an unusually large amount of food within a 2-hour period (an amount that most people would agree is unusually large?

☐ No ☐ Yes

2) During the time when you ate an unusually large amount of food, did you often feel you could not stop eating or control what or how much you were eating?

☐ No ☐ Yes

If NO, do not complete questions 3-10, but skip to question 11 in this section.

3) During the past 6 months, how often, on average, did you have times when you ate unusually large amounts of food *AND* felt that your eating was out of control?
(There may have been some weeks when it was not present – just average those in)
Please tick:

☐ Less than one day a week
☐ One day a week
☐ Two or three days a week
☐ Four or five days a week
☐ Nearly every day

4) Did you ***usually*** have any of the following experiences during these occasions?
Please tick yes or no for each item in this table.

	Yes	**No**
Eating much more rapidly than usual?		
Eating until you felt uncomfortably full?		
Eating large amounts of food when you didn't feel physically hungry?		
Eating alone because you were embarrassed by how much you were eating?		
Feeling disgusted with yourself, depressed, or feeling very guilty after overeating?		
Eating large amounts of food throughout the day with no planned mealtimes?		

5) Think about a typical time when you ate this way (large amounts of food *and* feeling that your eating was out of control).

a) What time of day did the episode start?
Please tick:

☐ Morning (8am to 12 noon)
☐ Early afternoon (12 noon to 4pm)
☐ Late afternoon (4pmto 7pm)
☐ Evening (7pmto 10pm)
☐ Night (after 10pm)

b) Approximately how long did this episode of eating last, from the time you started to eat until when you stopped and did not eat again for *at least* 2 hours?

_____ hours _____ minutes

c) As best you can remember, please list *everything* you might have *eaten* or *drunk* during that episode. If you ate for more than 2 hours, describe the food eaten and liquids drunk that you ate the most. Be specific - include amounts and brand names (when possible). Estimate as best as you can.

For example: 150g Ruffles potato chips; 1 cup Paul's chocolate ice cream with 2 teaspoons of hot fudge; 2 x 250ml glasses of Coca-Cola; and 2 ham and cheese sandwiches with mustard.

Food	Brand (if possible)	Amount

d) At the time this episode started, how long had it been since you had previously finished eating a meal or snack?

_____ hours _____ minutes

6) In general, during the past 6 months, how upset were you by overeating episodes in which you ate unusually large amounts of food?
Please tick:

☐ Not at all
☐ Slightly
☐ Moderately
☐ Greatly
☐ Extremely

7) In general, during the past 6 months, how upset were you by feeling that you could not stop eating or could not control what or how you were eating?
Please tick:

☐ Not at all
☐ Slightly
☐ Moderately
☐ Greatly
☐ Extremely

8) In general, during the past 6 months, how important has your weight or shape been in how you feel about or evaluate yourself as a person - compared to other aspects of your life (i.e., how you do at work, as a parent, or how you get along with other people)?
Please tick:

☐ Were not very important
☐ Played a part in how I felt about myself
☐ Were among the main things that affected how I felt about myself
☐ Were the most important things that affected how I felt about myself.

9) During the past ***three*** months, did you ever make yourself vomit in order to avoid gaining weight after binge eating? ☐ No ☐ Yes

If Yes, how often on average?

☐ Less than once a week
☐ Once a week
☐ Two or three times a week
☐ Four or five times a week
☐ More than five times a week

10) During the past ***three*** months, did you ever take more than twice the recommended dose of laxatives in order to avoid gaining weight after binge eating? ☐ No ☐ Yes

If Yes, how often on average?

☐ Less than once a week
☐ Once a week
☐ Two or three times a week
☐ Four or five times a week
☐ More than five times a week

11) During the past ***three*** months, did you ever take more than twice the recommended dose of diuretics (water pills) in order to avoid gaining weight after binge eating? ☐ No ☐ Yes

If Yes, how often on average?

☐ Less than once a week
☐ Once a week
☐ Two or three times a week
☐ Four or five times a week
☐ More than five times a week

12) During the past ***three*** months, did you ever fast (not eat anything at all for at least 24 hours) in order to avoid gaining weight after binge eating? ☐ No ☐ Yes

If Yes, how often on average?

☐ Less than once a week
☐ Once a week
☐ Two or three times a week
☐ Four or five times a week
☐ More than five times a week

13) During the past ***three*** months, did you ever exercise for more than 1 hour specifically in order to avoid gaining weight after eating? ☐ No ☐ Yes

If Yes, how often on average?

- ☐ Less than once a week
- ☐ Once a week
- ☐ Two or three times a week
- ☐ Four or five times a week
- ☐ More than five times a week

14) During the past ***three*** months, did you ever take more than twice the recommended dosage of a diet pill in order to avoid gaining weight after binge eating? ☐ No ☐ Yes

If Yes, how often on average?

- ☐ Less than once a week
- ☐ Once a week
- ☐ Two or three times a week
- ☐ Four or five times a week
- ☐ More than five times a week

(K) EATING HABITS

In reference to the past 6 months, please circle ONE answer for each question in this Part.

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

0 None	1 Very Low	2 Low	3 Moderate	4 High

2. When do you usually eat for the first time?

6am	9am	Noon	3pm	6pm or later

3. How much of your daily food intake do you consume *after* supper?

0%	25%	50%	75%	100%

4. How often do you have trouble getting to sleep?

0 Never	1 Sometimes	2 Half the Time	3 Usually	4 Always

5) How often do you get up in the middle of the night?

0 Never	1 Once a Month	2 Once a Week	3 Once a Night	4 More than Once

6) When you get up in the middle of the night, how often do you snack?

0 Never	1 Sometimes	2 Half the Time	3 Usually	4 Always

7a) To what extent do you have cravings or urges to eat snacks after supper, but before bedtime?

0 None at all	1 A little	2 Somewhat	3 Very much so	4 Extremely so

7b) To what extent do you have cravings or urges to eat snacks when you wake up at night?

0 None at all	1 A little	2 Somewhat	3 Very much so	4 Extremely so

8) To what extent do you believe you need to eat in order to get back to sleep when you awake at night?

0 None at all	1 A little	2 Somewhat	3 Very much so	4 Extremely so	5 I don't wake

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

0 None at all	1 A little	2 Somewhat	3 Very much so	4 Extremely so	5 I don't snack

10) Are you feeling blue or down in the dumps?

0 None at all	1 A little	2 Somewhat	3 Very much so	4 Extremely so

11) When you are feeling blue, when is your mood better?

Early Morning	Late Morning	Afternoon	Early Evening	Late evening

12) When you are feeling blue, when is your mood lower?

Early Morning	Late Morning	Afternoon	Early Evening	Late evening

13) How long has your current episode of difficulty with night eating been going on?

Never	3 Months	6 Months	9 Months	1 Year	More than 1 year

(L) PHYSICAL ACTIVITY

How many sessions of exercise do you do per week for more that 30 minutes at a time?

_____

How do you feel when exercising? Please mark the line with a cross (**X**) in the position that best indicates your answer.

0 _____ 10
Awful Average Excellent

Do you have any physical problems that limit your physical activity? ☐ No ☐ Yes
If yes, please describe:
_____

Please tick the types of physical activity you enjoy, but tick only those that you have participated in during the last year:

☐ Walking outside
☐ Walking indoors (e.g. treadmill)
☐ Jogging
☐ Running
☐ Cycling outside
☐ Cycling indoors (e.g. stationary bike)
☐ Aerobics classes
☐ Tennis / Racquetball
☐ Swimming
☐ Basketball
☐ Golf
☐ Strength work (e.g. weights)
☐ Other (please specify): _____

For your most preferred activity, how many times have you participated in this activity in the past 6 months? _____ Times

How many sessions of exercise do you do per week for more that 30 minutes at a time? _____

How many hours of TV do you watch on an average weekday? _____ Hours

How many hours of TV do you watch on an average weekend day? _____ Hours

Approximately how many city blocks or the equivalent do you regularly walk each day?
_____ Blocks (12 blocks = 1.6km = 1 mile)

How many flights of stairs do you climb up each day?
_____ Flights/day (where 1 flight = 10 steps

Please describe your daily lifestyle activity (i.e, how active you are) by picking any number from1 to10 where **1** = "**very sedentary**" and **10** = "**very active.**"

Your number: _____

(L) FEELINGS

	Yes	No	Maybe
Are you a ***perfectionist***, a person who always wants to be ***in control***, an ***overachiever*** and/or do you think no matter what you do it is never enough?			
Do you find that you seek or desire ***acceptance and/or approval from people***, and/or that you have a hard time saying "no"?			
Do you find that you are always ***questioning your own judgments*** and/or actions, and/or do you scrutinize yourself over small faults?			
Do you think you are not good enough, stupid and/or worthless or that ***people are always judging you*** in a negative way?			
Do you hide your feelings and/or opinions from people for ***fear of being judged negatively***, and/or do you feel like a burden to others with your problems?			
Within your family and/or circle of friends are you considered ***"the strong one"*** who everyone will come to with problems, and/or you never seem to talk much about your own?			
Do you think ***life would be better*** and/or people would like you more if you were thin/thinner?			
Do you find yourself often ***comparing*** your appearance and weight to others, strangers and/or models and actors, and wishing to be as "nice looking" or as "thin" as they are?			
Do you continuously feel that you are ***overweight/ underweight*** even though others have told you that you are not?			
Do family members and/or friends often express ***concern for your weight-loss/ gain***, your appearance, and/or your eating habits?			
Do you think ***everyone's problems*** are more important then your own, or do you belittle your own emotions and pain?			
Do you often ***feel numb or empty inside***, like your life lacks fulfilment and happiness, like something is missing or there is a void inside?			
Do you feel as though you have a "conscience" or "voice" that tells you ***negative things*** about yourself, convinces you that you do not deserve to eat and/or to be happy, or that tells you that you are or deserve to be fat and ugly?			
Examining yourself and how you feel, do you believe that you may suffer from ***Anorexia, Bulimia or Compulsive Overeating***, or any combination of the three?			
Do you suffer from ***bouts of depression***, hopelessness, and/or lack of motivation; and/or do you find your own problems overwhelming and hard to handle?			
Are you depressed, ***suicidal***, stressed-out, and/or fatigued; and/or do you suffer from ***anxiety or panic attacks***, mood swings, rage and/or insomnia?			
Have you ever ***been diagnosed*** with clinical depression, attentive deficit disorder, manic depression, bipolar disorder, post-traumatic stress disorder, obsessive-compulsive disorder, or dissociative identity disorder, or any other psychological/ neurological illness?			

(M) BEHAVIOURS

"PURGING" IS DEFINED AS ANY BEHAVIOR USED TO TRY TO RID THE BODY OF FOOD (AND SOMETIMES FEELINGS) - THIS INCLUDES SELF-INDUCED VOMITING, RESTRICTION AND STARVATION OR FASTING PERIODS AFTER BINGING, COMPULSIVELY EXERCISING, TAKING LAXATIVES OR DIURETICS, ETC.

	Yes	No	Maybe
Do you eat, self-starve or restrict, binge and/or purge, and/or compulsively exercise when you are feeling lonely, badly about yourself or about a situation, or when you are feeling emotional pressures?			
While eating, self-starving, or binging and/or purging do you feel comforted, relieved, like emotional pressures have been lifted, or like you are in more control?			
Do you feel guilty following a binge and/or purge episode, after eating or during and/or after periods of restriction/self-starvation?			
When eating do you ever feel out of control or like you will lose control and not be able to stop; and/or do you try to avoid eating because of this fear?			
Do you typically feel guilty after a binge, or after any snack or meal, and like you have almost instantly gained weight, like you are a failure, and/or like you have sabotaged yourself?			
Do you use self-starvation, purging, diet pills, laxatives, diuretics, and/or obsessively exercise as a way to attempt to lose weight?			
Do you drink a lot of water, tea or coffee, eat a lot of sweets or junk food and/or gum, smoke, and/or take caffeine pills as an attempt to control appetite and/or feel more energetic?			
Do you abuse alcohol, drugs or prescription medication, and/or practice in self-hurting behaviour such as cutting?			
Do you weigh yourself often and does the number on the scale dictate your mood and/or self-worth for the day; and/or do you find you are continuously trying to get that number lower?			
Are you constantly "on a diet", and/or counting calories and fat grams; and/or do you feel like you've tried every "fad diet" or "lose weight quick" scheme?			
Do you set weight-goals for yourself only to find when you reach it that you want to lose more or once reached give in to poor eating habits again resulting in rapid rebound in weight?			
Do you do any of the following: hide and/or steal food, laxatives and/or diet pills; eat and/or exercise secretively; avoid eating in public or around others; wear clothes that hide your weight; and/or make excuses (like "I don't feel well) to avoid meals?			
Are you secretive about your eating practices, do you think they are abnormal, and/or would you avoid recommending your excessive / restrictive eating methods to a family member or friend?			
Would you worry about a friend or family member that came to you with similar weight-management/coping methods?			
Do you lie about your eating behaviours, hide them from others at all costs, and/or would you lie or steal to see they could continue?			
Do you use self-injury (cutting yourself, burning yourself, pulling out your own hair) as a way to cope with things?			
Do you spend a lot of time obsessively cooking or reading recipes, and/or studying the nutritional information on food (calories, fat grams, etc.)?			
Do you do one or more of the following [harmful] Eating Disorder behaviours: *- Restrict food intake or starve yourself* *(eat very little, eat nothing, or try to eat as little as possible)* *- Binge (eat large quantities of food in a short period of time);* *- Purge (use methods such as self-induced vomiting or laxatives to attempt to "get rid of" what you've eaten);* *- Compulsively Overeat (eat even if you are not hungry* *- Compulsively Exercise* *(exercise too much, too vigorously, or where it is intrusive in your life)* *- Take diet pills, laxatives, diuretics or other pills or harmful substances to help you curb appetite or assist in purging;* *- Chewing/Spitting (putting food in your mouth, chewing it up and then spitting it out -- this is another form of binging/purging)*			

(N) PHYSICAL SIGNS

	Yes	No	Maybe
Are you **temperature sensitive** (always feel cold or hot), and/or do you get tingling in your extremities (hands and feet)?			
Do you find that you **bruise easily**, have a very high tolerance for pain, and/or you are extremely **noise sensitive** (even only slightly loud noises irritate you).			
Are you unrealistically **tired** relative to the amount of energy expended (eg. do you feel winded or dizzy after climbing a flight of stairs), and/or do you find yourself often fatigued?			
Do you suffer any of the following: **heart palpitations** and/or **chest pains; fainting spells, blackouts or dizziness**; chronic lower back pain, headaches or lightheadedness, tingling in arms or legs, numbness in face or other parts of the body, joint pain, excitability, mood swings, hyperactivity; low blood pressure and/or body temperature or escalated blood pressure or cholesterol; and/or chronically sick with cold or flu.			
Do you suffer any of the following: disruption in menstrual cycle and/or irregularity, **infertility, decreased sex drive**, irritability; lack of ability to concentrate, blurred vision; kidney and/or urinary tract infections; sore throats, dental problems; stomach cramping, blood in stools or vomit, diarrhea, constipation and/or incontinence (loss of bowel control); insomnia, fatigue, and/or anxiety or depression?			

(O) SELF-PERCEPTIONS

How satisfied are you with your current weight? (tick one):

☐ Very satisfied ☐ Dissatisfied

☐ Moderately satisfied ☐ Neutral ☐ Moderately dissatisfied

☐ Slightly satisfied ☐ Very Dissatisfied

How satisfied are you with your current shape (ie figure/physique) ? (tick one):

☐ Very satisfied ☐ Dissatisfied

☐ Moderately satisfied ☐ Neutral ☐ Moderately dissatisfied

☐ Slightly satisfied ☐ Very Dissatisfied

How satisfied are you with your current overall appearance? (tick one):

☐ Very satisfied ☐ Dissatisfied

☐ Moderately satisfied ☐ Neutral ☐ Moderately dissatisfied

☐ Slightly satisfied ☐ Very Dissatisfied

Pick the one sentence that best describes your *overall* feelings about yourself:

"In general, I am . . ."

☐ Very happy with who I am

☐ Happy with who I am

☐ OK with who I am, but I have some mixed feelings

☐ Unhappy with who I am

☐ Very unhappy with who I am

Pick the one sentence that best describes you:

"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

Pick the one sentence that best describes your feelings about the way you looked the last time you lost a lot of weight.

"I was .. ."

☐ Very happy with the way I looked

☐ Happy with the way I looked

☐ OK with the way I looked, but I have some mixed feelings

☐ Unhappy with the way I looked

☐ Very unhappy with the way I looked

How much weight did you lose? _____

At what weight did you start the diet at that time? _____

(P) PSYCHOLOGICAL FACTORS

Have you ever had any problems at any time with depression, anxiety, or other emotions that disrupted your normal functioning? ☐ No ☐ Yes

Have you ever sought professional help for emotional problems? ☐ No ☐ Yes

If yes, please specify:

Year	Type of Professional Help	Problem	Duration (weeks)

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

☐ No ☐ Yes

During the past month, have you often felt hopeless about the future?

☐ No ☐ Yes

During the past month, have you had little interest or pleasure in doing things?

☐ No ☐ Yes

Have you ever been subjected to physical abuse?

☐ No ☐ Yes

Have you ever been subjected to sexual abuse?

☐ No ☐ Yes

Are any of your immediate family members alcoholic?

☐ No ☐ Yes

(Q) TIMING

Please indicate if you are currently experiencing any stress in your life related to the following events. (Tick yes or no):

	Yes	No
Work		
Health		
Relationship with spouse/ significant other		
Activities related to your children		
Activities related to your parents		
Legal/financial trouble		
School		
Moving		
Other		

Please provide further information on any item to which you responded yes:

Are you planning any major life changes during the net 6 months (i.e. new job, moving)?

☐ No ☐ Yes

If yes, please describe:

How stressful has your life been during the past 6 months?

1	2	3	4	5
Much less stressful than usual	Less stressful than usual	Average level of stress	More stressful than usual	Much more stressful than usual

How stressful do you think that your life will be in the next 6 months, excluding your efforts to lose weight?

1	2	3	4	5
Much less stressful than usual	Less stressful than usual	Average level of stress	More stressful than usual	Much more stressful than usual

How motivated are you to lose weight at this time? Pick a number between 1 and 10, in which **1 = "not motivated"** and **10 = "greatest motivation you have ever had."**

Your number is _____

Why do you want to lose weight right now, as compared to 1 year ago (what has prompted you to lose weight now?

_____

_____

What is the single most important thing that you hope to achieve as a result of losing weight?

_____

_____

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, exercise, and thinking habits. Please tick the sentence below that 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 exercise habits.
Pick a number from 1 to 10 in which **1 = "not at all confident"** and **10 = "extremely confident."**

Your number is _____

Please use this space to discuss any other information that you think is important to understanding you and/or your weight and your successful participation in the program.

_____

_____

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(R) MHLC

Instructions: Each item below is a belief statement about your medical condition with which you may agree or disagree. Beside each statement is a scale which ranges from strongly disagree (1) to strongly agree (6). For each item we would like you to circle the number that represents the extent to which you agree or disagree with that statement. The more you agree with a statement, the higher will be the number you circle. The more you disagree with a statement, the lower will be the number you circle. Please make sure that you answer **EVERY ITEM** and that you circle **ONLY ONE** number per item. This is a measure of your personal beliefs; there are no right or wrong answers.

1=STRONGLY DISAGREE **(SD)** 2=MODERATELY DISAGREE **(MD)** 3=SLIGHTLY DISAGREE **(D)**	4=SLIGHTLY AGREE **(A)** 5=MODERATELY AGREE **(MA)** 6=STRONGLY AGREE **(SA)**

1	If I get sick, it is my own behaviour which determines how soon I get well again.	1	2	3	4	5	6
2	No matter what I do, if I am going to get sick, I will get sick.	1	2	3	4	5	6
3	Having regular contact with my physician is the best way for me to avoid illness.	1	2	3	4	5	6
4	Most things that affect my health happen to me by accident.	1	2	3	4	5	6
5	Whenever I don't feel well, I should consult a medically trained professional.	1	2	3	4	5	6
6	I am in control of my health.	1	2	3	4	5	6
7	My family has a lot to do with my becoming sick or staying healthy.	1	2	3	4	5	6
8	When I get sick, I am to blame.	1	2	3	4	5	6
9	Luck plays a big part in determining how soon I will recover from an illness.	1	2	3	4	5	6
10	Health professionals control my health.	1	2	3	4	5	6
11	My good health is largely a matter of good fortune.	1	2	3	4	5	6
12	The main thing which affects my health is what I myself do.	1	2	3	4	5	6
13	If I take care of myself, I can avoid illness.	1	2	3	4	5	6
14	Whenever I recover from an illness, it's usually because other people (for example, doctors, nurses, family, friends) have been taking good care of me.	1	2	3	4	5	6
15	No matter what I do, I 'm likely to get sick.	1	2	3	4	5	6
16	If it's meant to be, I will stay healthy.	1	2	3	4	5	6
17	If I take the right actions, I can stay healthy.	1	2	3	4	5	6
18	Regarding my health, I can only do what my doctor tells me to do.	1	2	3	4	5	6

(S) MDBSRQ

The following section contains a series of statements about how people might think, feel, or behave. You are asked to indicate the extend to which each statement pertains to you personally. Read each statement carefully. Circle the most appropriate number on

1 = Definitely disagree
2 = Mostly disagree
3 = Neither agree or disagree
4 = Mostly agree
5 = Definitely agree

Office Use Only	
AE	___/7 (35)
AO	___/12 (60)

1.	1 2 3 4 5	Before going out in public, I always notice how I look.
2.	1 2 3 4 5	I am careful to buy clothes that will make me look my best.
3.	1 2 3 4 5	My body is sexually appealing.
4.	1 2 3 4 5	I like my looks just the way they are.
5.	1 2 3 4 5	I check my appearance in a mirror whenever I can.
6.	1 2 3 4 5	Before going out, I usually spend a lot of time getting ready.
7.	1 2 3 4 5	Most people would consider me good-looking.
8.	1 2 3 4 5	It is important that I always look good.
9.	1 2 3 4 5	I use very few grooming products.
10.	1 2 3 4 5	I like the way I look without my clothes.
11.	1 2 3 4 5	I am self-conscious if my grooming isn't right.
12.	1 2 3 4 5	I usually wear whatever is handy without caring how it looks.
13.	1 2 3 4 5	I like the way my clothes fit me.
14.	1 2 3 4 5	I don't care what people think about my appearance.
15.	1 2 3 4 5	I take special care with my hair grooming.
16.	1 2 3 4 5	I dislike my physique.
17.	1 2 3 4 5	I am physically unattractive.
18.	1 2 3 4 5	I never think about my appearance.
19.	1 2 3 4 5	I am always trying to improve my physical appearance

(T) HEALTH SURVEY

	Question	**Answer**	**Score (Office Only)**
Example	**In general, would you say your health is:** Excellent (1) Very good (2) Good (3) Fair (4) Poor (5)	4	
1	**In general, would you say your health is:** Excellent (1) Very good (2) Good (3) Fair (4) Poor (5)		
2	**Compared to one year ago, how would your rate your health in general now?** Much better now than one year ago (1) Somewhat better now than one year ago (2) About the same (3) Somewhat worse now than one year ago (4) Much worse now than one year ago (5)		

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

3	**Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports** Yes, Limited a Lot (1) Yes, Limited a Little (2) No, Not limited at All (3)		
4	**Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf** Yes, Limited a Lot (1) Yes, Limited a Little (2) No, Not limited at All (3)		
5	**Lifting or carrying groceries** Yes, Limited a Lot (1) Yes, Limited a Little (2) No, Not limited at All (3)		
6	**Climbing several flights of stairs** Yes, Limited a Lot (1) Yes, Limited a Little (2) No, Not limited at All (3)		
7	**Climbing one flight of stairs** Yes, Limited a Lot (1) Yes, Limited a Little (2) No, Not limited at All (3)		
8	**Bending, kneeling, or stooping** Yes, Limited a Lot (1) Yes, Limited a Little (2) No, Not limited at All (3)		
9	**Walking more than a mile** Yes, Limited a Lot (1) Yes, Limited a Little (2) No, Not limited at All (3)		
10	**Walking several blocks** Yes, Limited a Lot (1) Yes, Limited a Little (2) No, Not limited at All (3)		
11	**Walking one block** Yes, Limited a Lot (1) Yes, Limited a Little (2) No, Not limited at All (3)		
12	**Bathing or dressing yourself** Yes, Limited a Lot (1) Yes, Limited a Little (2) No, Not limited at All (3)		

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

13	**Cut down the amount of time you spent on work or other activities** Yes (1) No (2)		
14	**Accomplished less than you would like** Yes (1) No (2)		
15	**Were limited in the kind of work or other activities** Yes (1) No (2)		
16	**Had difficulty performing the work or other activities (for example, it took extra effort)** Yes (1) No (2)		

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

17	**Cut down the amount of time you spent on work or other activities** Yes (1) No (2)		
18	**Accomplished less than you would like** Yes (1) No (2)		
19	**Didn't do work or other activities as carefully as usual** Yes (1) No (2)		
20	**During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?** Not at all (1) Slightly (2) Moderately (3) Quite a bit (4) Extremely (5)		
21	**How much bodily pain have you had during the past 4 weeks?** None (1) Very mild (2) Mild (3) Moderate (4) Severe (5) Very severe (6)		
22	**During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?** Not at all (1) Slightly (2) Moderately (3) Quite a bit (4) Extremely (5)		

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

23	**Did you feel full of pep?** All of the Time (1) Most of the Time (2) A Good Bit of the Time (3) Some of the Time (4) A Little of the Time (5) None of the Time (6)		
24	**Have you been a very nervous person?** All of the Time (1) Most of the Time (2) A Good Bit of the Time (3) Some of the Time (4) A Little of the Time (5) None of the Time (6)		
25	**Have you felt so down in the dumps that nothing could cheer you up?** All of the Time (1) Most of the Time (2) A Good Bit of the Time (3) Some of the Time (4) A Little of the Time (5) None of the Time (6)		

26	**Have you felt calm and peaceful?** All of the Time (1) Most of the Time (2) A Good Bit of the Time (3) Some of the Time (4) A Little of the Time (5) None of the Time (6)		
27	**Did you have a lot of energy?** All of the Time (1) Most of the Time (2) A Good Bit of the Time (3) Some of the Time (4) A Little of the Time (5) None of the Time (6)		
28	**Have you felt downhearted and blue?** All of the Time (1) Most of the Time (2) A Good Bit of the Time (3) Some of the Time (4) A Little of the Time (5) None of the Time (6)		
29	**Did you feel worn out?** All of the Time (1) Most of the Time (2) A Good Bit of the Time (3) Some of the Time (4) A Little of the Time (5) None of the Time (6)		
30	**ave you been a happy person?** All of the Time (1) Most of the Time (2) A Good Bit of the Time (3) Some of the Time (4) A Little of the Time (5) None of the Time (6)		
31	**Did you feel tired?** All of the Time (1) Most of the Time (2) A Good Bit of the Time (3) Some of the Time (4) A Little of the Time (5)		
32	**During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?** All of the time (1) Most of the time (2) Some of the time (3) A little of the time (4)		

How TRUE or FALSE is each of the following statements for you?

33	**I seem to get sick a little easier than other people.** Definitely true (1) Mostly true (2) Don't know (3) Mostly false (4) Definitely false (5)		
34	**I am as healthy as anybody I know.** Definitely true (1) Mostly true (2) Don't know (3) Mostly false (4) Definitely false (5)		
35	**I expect my health to get worse.** Definitely true (1) Mostly true (2) Don't know (3) Mostly false (4) Definitely false (5)		
36	**My health is excellent.** Definitely true (1) Mostly true (2) Don't know (3) Mostly false (4) Definitely false (5)		

(U) CERTIFICATION

I certify that the information provided in this form is true and accurate to the best of my knowledge.
I understand that this information needs to be accurate to support my intervention in weight loss.

Name (please print): _____

Signature: _____ Date: _____