WEIGHT AND LIFESTYLE INVENTORY

© 2015 Thomas A. Wadden, Ph.D. and Gary D. Foster, Ph.D.

Further information about the Weight and Lifestyle Inventory (WALI) may be obtained from a supplementary issue of the journal, Obesity, published in March 2006 (Obesity 2006 Mar; 14 Suppl 2:515-1183).

Permission to use the WALI may be obtained by contacting Thomas A. Wadden at wadden@pennmedicine.upenn.edu.
The Weight and Lifestyle Inventory (WALI) is designed to obtain information about your weight and dieting histories, your eating and exercise habits, and your relationships with family and friends. Please complete the questionnaire carefully and make your best guess when unsure of the answer. You will have an opportunity to review your answers with a member of our professional staff.

Please allow 30-60 minutes to complete this questionnaire. Your answers will help us better identify problem areas and plan your treatment accordingly. The information you provide may be shared with members of our treatment team. Thank you for taking the time to complete this questionnaire.

SECTION A: IDENTIFYING INFORMATION

1. Name _____________________________________________ lbs. ______ ft. ______ inches

2. Date of Birth ________________________ Age

3. Weight

4. Height

5. Address

6. Phone: Cell __________________________ Phone: Home __________________________ Occupation/# of yrs. at job

7. Phone: Home

8. Phone: Home

9. Occupation/# of yrs. at job

10. Today’s Date __________________________

11. Highest year of school completed: (Check one.)

□ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ 12 □ 13 □ 14 □ 15 □ 16 □ Masters □ Doctorate

Middle School High School College

12. Race (Check all that apply): □ American Indian □ Asian □ African American/Black

□ Pacific Islander □ White □ Other: ______________________

13. Are you Latino, Hispanic, or of Spanish origin? □ Yes □ No

SECTION B: WEIGHT HISTORY

1. At what age were you first overweight by 10 lbs. or more? _______ yrs. old

2. What has been your highest weight after age 21? _______ lbs. _______ yrs. old at the time

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

For office use:

Interviewer: ____________________________ Date of interview: _________________
4. For each time period shown below, please list your maximum weight. If you cannot remember what your maximum weight was, make your best guess and mark “G” (for guess) next to your answer. In addition, please note any events related to your gaining weight during this period. For ages 16 and beyond, please identify the figure, from those shown below, the most resembles your figure at that time. Record the number of the figure.

<table>
<thead>
<tr>
<th>AGE</th>
<th>MAXIMUM WEIGHT</th>
<th>FIGURE #</th>
<th>EVENTS RELATED TO WEIGHT GAIN</th>
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<td>a. 5-10</td>
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<td>b. 11-15</td>
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<td>c. 16-20</td>
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<td>j. 60-70</td>
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SECTION C: FAMILY WEIGHT HISTORY

1. Please indicate the approximate height and weight of your biological mother and father when they were 40-50 years old. Please select from the previous figures the ones that are most similar to your parents’ body shapes. If you do not know your biological parents’ height and weight, please mark NA (not applicable) in the spaces.

<table>
<thead>
<tr>
<th>Parent</th>
<th>Height (ft.+in.)</th>
<th>Weight (lbs.)</th>
<th>Current Age (or year of death)</th>
<th>Figure # (from previous page)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Mother</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td>______</td>
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<tr>
<td>b. Father</td>
<td>______</td>
<td>______</td>
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</table>

Please provide the same information for your current spouse or significant other. (Leave blank if not applicable.)

c. Spouse/ Significant Other

| ______ | ______ | ______ | ______ |

2. For each of your grandparents (who are biologically related to you), please check whether they are (were) overweight or obese as an adult. Check “DK” if you don’t know.

- Your mother’s mother: □ Yes □ No □ DK
- Your father’s mother: □ Yes □ No □ DK
- Your mother’s father: □ Yes □ No □ DK
- Your father’s father: □ Yes □ No □ DK

3. How many brothers do you have (who are biologically related to you)? ______

How many are (were) overweight or obese? ______

4. How many sisters do you have (who are biologically related to you)? _____

How many are (were) overweight or obese? ______

SECTION D: WEIGHT, PREGNANCY, AND MENSTRUAL CYCLE
(For Women Only)

1. Have you borne children? (Check one) □ Yes □ No

If yes,

- a. What was your weight at the start of your first pregnancy? ______lbs.
   What was your weight at delivery? ______lbs.
   What was your lowest weight after delivery? ______lbs.

- b. What was your weight at the start of your second pregnancy? ______lbs.
   What was your weight at delivery? ______lbs.
   What was your lowest weight after delivery? ______lbs.

- c. What was your weight at the start of your third pregnancy? ______lbs.
   What was your weight at delivery? ______lbs.
   What was your lowest weight after delivery? ______lbs.

- d. What was your weight at the start of your fourth pregnancy? ______lbs.
   What was your weight at delivery? ______lbs.
   What was your lowest weight after delivery? ______lbs.

Please turn to the last page if you need more space.
2. Do you experience a regular menstrual cycle? □ Yes □ No
   If yes, describe your eating around the time of your menstruation. (Check one)
   □ Eat much less □ Eat less □ No Change □ Eat More □ Eat Much More

SECTION E: WEIGHT LOSS HISTORY

1. Please record your major weight loss efforts, (e.g., diet, exercise, medication, etc.) which resulted in a weight loss of 10 pounds or more. 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. Start with your first weight loss effort and proceed in order. If you have had more than seven efforts on which you lost 10 pounds or more, please list your largest losses.

<table>
<thead>
<tr>
<th>Age at time of effort</th>
<th>Weight at start of effort</th>
<th># lbs. lost</th>
<th>Method used to lose weight</th>
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<td>g.</td>
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</table>

Please turn to the last page if you need additional space.

2. Please indicate the total number of diets on which you have lost 10 pounds or more if you have had more than seven diets. ______

3. Please list any weight loss medications you have used, even if you did not lose 10 pounds or more.
   1. ________________________  2. ________________________  3. ________________________

4. Please list any commercial weight loss programs you have used, even if you did not lose 10 pounds or more.
   1. ________________________  2. ________________________  3. ________________________

SECTION F: WEIGHT LOSS GOALS

1. How much weight would you like to lose at this time? ______ lbs.

2. This would bring you down to a body weight of ______ lbs.

3. At what age did you last weigh this amount? ______ years
SECTION G: TOBACCO AND ALCOHOL USE

1. Do you currently smoke cigarettes (tobacco)? □ Yes □ No
   If yes,
   a. How many cigarettes do you smoke a day? _______
   b. How many years have you smoked? _______

2. Have you ever smoked cigarettes (tobacco) and stopped? □ Yes □ No
   If yes,
   a. When did you stop smoking? _______
   b. How many cigarettes did you smoke? _______/day
   c. Did you experience any weight gain after stopping smoking? □ Yes □ No
      If yes, how many pounds? _______

3. Do you currently smoke e-cigarettes? □ Yes □ No
   If yes,
   a. How many cartridges do you smoke a day? _______
   b. How many years have you smoked e-cigarettes? _______

4. During the past year:
   a. How many glasses of wine did you typically drink a week? _______
   b. How many bottles of beer did you typically drink a week? _______
   c. How many mixed drinks or liqueurs did you typically have a week? _______

5. Have you ever had a problem with your alcohol consumption? □ Yes □ No
   If yes, please describe the problem and any help you received for it.
   ____________________________________________________________________________
   ____________________________________________________________________________

6. Have any of your immediate family members ever had a problem with alcohol consumption? □ Yes □ No

7. Have you ever had a problem with the use of recreational drugs or prescription medications? □ Yes □ No
   If yes, please describe the problem and any help you received for it.
   ____________________________________________________________________________
   ____________________________________________________________________________

SECTION H: EATING HABITS

1. Please check the behaviors below that are a problem for you and which you believe contribute to weight gain.
   □ Overeating at breakfast                      □ Eating because of the good taste of foods
   □ Overeating at lunch                           □ Eating while cooking or preparing food
   □ Overeating at dinner                          □ Eating when anxious
   □ Snacking between meals                        □ Eating when tired or bored
   □ Snacking after dinner                         □ Eating when stressed or angry
   □ Eating because I feel physically hungry      □ Eating when depressed or upset
   □ Eating because I crave certain foods          □ Eating when socializing/celebrating
   □ Continuing to eat because I don’t feel full after a meal □ Eating when alone
   □ Eating because I can’t stop once I’ve begun □ Eating with family or friends
   □ Eating at business functions
Please describe any other factors that contribute significantly to your gaining weight.

___________________________________________________________________________________________
___________________________________________________________________________________________

2. How many days a week do you eat the following meals? Write the number of days in the space and the usual time of each meal.

   a. Breakfast _______ days a week Time: _______ Morning Snack _______ days a week Time: _______
   b. Lunch _______ days a week Time: _______ Afternoon Snack _______ days a week Time: _______
   c. Dinner _______ days a week Time: _______ Evening Snack _______ days a week Time: _______

3. Who prepares meals at your home? ___________________________________________________________

4. Please specify the amount (in cups, 8 oz.) of the following fluids you typically consume a day.

   ____ skim milk   ____ low-fat milk   ____ whole milk   ____ energy drinks   ____ other
   ____ fruit juice   ____ diet soda   ____ tea   ____ coffee   ____ diet drinks
   ____ water   ____ regular soda   ____ wine   ____ sports drinks

5. During a typical week, how many meals do you eat at a fast food restaurant (including drive thru and convenience stores)?

   Breakfast _______ meals a week
   Lunch _______ meals a week
   Dinner _______ meals a week

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

   Breakfast _______ meals a week
   Lunch _______ meals a week
   Dinner _______ meals a week

SECTION I: FOOD INTAKE RECALL

Please indicate the foods you consume on a typical day.

<table>
<thead>
<tr>
<th>Meal</th>
<th>Time</th>
<th>Location</th>
<th>Food and Beverages Consumed</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast</td>
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<td>Morning Snack</td>
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<td>Evening Snack</td>
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SECTION J: EATING PATTERNS I
The Questionnaire on Eating and Weight Patterns is reprinted here with permission from Yanovski, S.Z., Marcus, M.D., Wadden, T.A. and Walsh, B.T., 2014. (Reprinted in the Int J Eating Disorders 2015.)

1. During the past three months, did you ever eat, in a short period of time – for example, a two hour period – what most people would think was an unusually large amount of food? □ Yes □ No

2. During the times when you ate an unusually large amount of food, did you ever feel you could not stop eating or control what or how much you were eating? □ Yes □ No

IF NO, SKIP TO QUESTION 7. Do not complete questions 3-6.

3. During the past three months, how often, on average, did you have episodes like this – that is, eating large amounts of food plus the feeling that your eating was out of control? (There may have been some weeks when it was not present- just average those in.) (Check one)

□ Less than 1 episode per week □ 4-7 episodes per week
□ 1 episode per week □ 8-13 episodes per week
□ 2-3 episodes per week □ 14 or more episodes per week

4. Did you usually have any of the following experiences during these occasions? (Complete all items.)

a. Eating much more rapidly than normal? □ Yes □ No
b. Eating until feeling uncomfortably full? □ Yes □ No
c. Eating large amounts of food when not feeling physically hungry? □ Yes □ No
d. Eating alone because of feeling embarrassed by how much you were eating? □ Yes □ No
e. Feeling disgusted with yourself, depressed, or feeling very guilty afterward? □ Yes □ No

5. Think about a typical episode when you ate this way (that is, when you ate a large amount of food and felt your eating was out of control):

a. What time of day did the episode start?
   □ (8 AM to 12 Noon) □ (12 Noon to 4 PM)
   □ (4 PM to 8 PM) □ (8 PM to 12 Midnight)
   □ (12 Midnight to 8 AM)

b. Approximately how long did this episode of eating last? _______ hours _______ minutes

c. As best as you can remember, please list everything you ate and drank during that episode. Please list the foods eaten and liquids consumed during the episode. Be specific- include brand names where possible and amounts or portion sizes as best you can estimate.

<table>
<thead>
<tr>
<th>FOOD</th>
<th>AMOUNT</th>
<th>BRAND (if possible)</th>
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</table>
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 three months, how upset were you by these episodes (when you ate a large amount of food and felt your eating was out of control)?

□ Not at all □ Slightly □ Moderately □ Greatly □ Extremely

7. During the past three months, did you ever make yourself vomit in order to avoid gaining weight after episodes of eating like you described (when you ate a large amount of food and felt your eating was out of control)? □ Yes □ No

If Yes: How often, on average, was that?

□ Less than 1 episode per week
□ 1 episode per week
□ 2-3 episodes per week
□ 4-7 episodes per week
□ 8-13 episodes per week
□ 14 or more episodes per week

8. During the past three months, did you ever take more than the recommended dose of laxatives in order to avoid gaining weight after episodes of eating like you described (when you ate a large amount of food and felt your eating was out of control)? □ Yes □ No

If Yes: How often, on average, was that?

□ Less than 1 time per week
□ 1 time per week
□ 2-3 times per week
□ 4-5 times per week
□ 6-7 times per week
□ 8 or more times per week

9. During the past three months, did you ever take more than the recommended dose of diuretics (water pills) in order to avoid gaining weight after episodes of eating like you described (when you ate a large amount of food and felt your eating was out of control)? □ Yes □ No

If Yes: How often, on average, was that?

□ Less than 1 time per week
□ 1 time per week
□ 2-3 times per week
□ 4-5 times per week
□ 6-7 times per week
□ 8 or more times per week

10. During the past three months, did you ever fast – for example, not eat anything at all for at least 24 hours -- in order to avoid gaining weight after episodes of eating like you described (when you ate a large amount of food and felt your eating was out of control)? □ Yes □ No

If Yes: How often, on average, was that?

□ Less than 1 day per week
□ 1 day per week
□ 2 days per week
□ 3 days per week
□ 4-5 days per week
□ More than 5 days per week

11. During the past three months, did you ever exercise excessively – for example, exercised even though it interfered with important activities or despite being injured – specifically in order to avoid gaining weight after episodes of eating like you described (when you ate a large amount of food and felt your eating was out of control)? □ Yes □ No

If Yes: How often, on average, was that?

□ Less than 1 time per week
□ 1 time per week
□ 2-3 times per week
□ 4-7 times per week
□ 8-13 times per week
□ 14 or more times per week

12. During the past three months, did you ever take more than the recommended dose of a diet pill in order to avoid gaining weight after episodes of eating like you described (when you ate a large amount of food and felt your eating was out of control)? □ Yes □ No
If Yes: How often, on average, was that?
   □ Less than 1 time per week
   □ 1 time per week
   □ 2-3 times per week
   □ 4-5 times per week
   □ 6-7 times per week
   □ 8 or more times per week

13. During the past three months, on average, how important has your weight or shape been in how you feel about or evaluate yourself as a person – as compared to other aspects of your life, such as your performance at work or as a parent, or how you get along with other people?
   □ Weight and shape were not very important
   □ Weight and shape played a part in how you felt about yourself
   □ Weight and shape were among the main things that affected how you felt about yourself
   □ Weight and shape were the most important things that affected how you felt about yourself

14. During the past three months, did you ever have episodes during which you felt you could not stop eating or control what or how much you were eating but in which you did not consume what most people would think was an unusually large amount of food? □ Yes □ No
   IF NO, SKIP TO SECTION K. Do not complete questions 15-18.

15. During the past three months how often did you have episodes like this -- the feeling that your eating was out of control, but you did not consume what most people would think was an unusually large amount of food? (There may have been some weeks when this did not happen -- just average those in.)
   □ Less than 1 episode per week
   □ 1 episode per week
   □ 2-3 episodes per week
   □ 4-7 episodes per week
   □ 8-13 episodes per week
   □ 14 or more episodes per week

16. Did you usually have any of the following experiences during these episodes?
   a. Eating much more rapidly than normal? □ Yes □ No
   b. Eating until feeling uncomfortably full? □ Yes □ No
   c. Eating large amounts of food when not feeling physically hungry? □ Yes □ No
   d. Eating alone because of feeling embarrassed by how much you were eating? □ Yes □ No
   e. Feeling disgusted with yourself, depressed, or feeling very guilty afterward? □ Yes □ No

17. Think about a typical episode when you ate this way (that is, when you felt you could not stop eating or control what or how much you were eating) but in which you did not consume an unusually large amount of food):
   a. What time of day did the episode start?
      □ (8 AM to 12 Noon)
      □ (12 Noon to 4 PM)
      □ (4 PM to 8 PM)
      □ (8 PM to 12 Midnight)
      □ (12 Midnight to 8 AM)
b. Approximately how long did this episode of eating last?
   ____ hours   ____ minutes

c. As best you can remember, please list everything you ate and drank during that episode. Please list the foods eaten and liquids consumed during the episode. Be specific – include brand names where possible, and amounts or portion sizes as best you can estimate.

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<th>FOOD</th>
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<th>BRAND (if possible)</th>
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d. At the time this episode started, how long had it been since you had previously finished eating a meal or snack?  ____ hours   ____ minutes

18. In general, during the past three months, how upset were you by these episodes (that is, when you felt you could not stop eating or control what or how much you were eating but in which you did not consume an unusually large amount of food)?

   □ Not at all   □ Slightly   □ Moderately   □ Greatly   □ Extremely

SECTION K: EATING PATTERNS II

Directions: Please check one answer for each question.

1. How hungry are you usually in the morning?
   □ Not at all   □ A little    □ Somewhat   □ Moderately   □ Very

2. When do you usually eat for the first time?
   □ Before 9 AM   □ 9:01 to 12 PM   □ 12:01 to 3 PM   □ 3:01 to 6 PM   □ 6:01 or later

3. Do you have cravings or urges to eat snacks after supper, but before bedtime?
   □ Not at all   □ A little    □ Somewhat   □ Very much so   □ Extremely so

4. How much control do you have over your eating between supper and bedtime?
   □ Not at all   □ A little    □ Some    □ Very much    □ Complete

5. How much of your daily food intake do you consume after supertime?
   □ 0% (none)   □ 1-25% (up to a quarter)   □ 26-50% (about half)
   □ 51-75% (more than half)   □ 76-100% (almost all)

6. Are you currently feeling blue or down in the dumps?
   □ Not at all   □ A little    □ Somewhat   □ Very much so   □ Extremely
7. When you are feeling blue, is your mood lower in the:
   □ Early morning  □ Late morning  □ Afternoon
   □ Early evening  □ Late evening/nighttime
   □ Check here if your mood does not change during the day

8. How often do you have trouble getting to sleep?
   □ Never  □ Sometimes  □ About half the time  □ Usually  □ Always

9. Other than only to use the bathroom, how often do you get up at least once in the middle of the night?
   □ Never  □ Less than once a week  □ About once a week
   □ More than once a week  □ Every night

*************** IF “NEVER” ON #9, PLEASE STOP HERE and Go to Section L***************

10. Do you have cravings or urges to eat snacks when you wake up at night?
    □ Not at all  □ A little  □ Somewhat  □ Very much so  □ Extremely so

11. Do you need to eat in order to get back to sleep when you awake at night?
    □ Not at all  □ A little  □ Somewhat  □ Very much so  □ Extremely so

12. When you get up in the middle of the night, how often do you snack?
    □ Never  □ Sometimes  □ About half the time  □ Usually  □ Always

*************** IF “NEVER” ON #12, PLEASE SKIP TO #15***************

12a. How many times per week do you usually eat when you wake up at night? ________ times per week

13. When you snack in the middle of the night, how aware are you of your eating?
    □ Not at all  □ A little  □ Some  □ Very much so  □ Completely

14. How much control do you have over your eating while you are up at night?
    □ None at all  □ A little  □ Some  □ Very much  □ Complete

15. How long have your difficulties with night eating been going on?
    ____________ months  ____________ years

16. Is your night eating upsetting to you?
    □ Not at all  □ A little  □ Somewhat  □ Very much so  □ Extremely

17. How much has your night eating affected your life?
    □ Not at all  □ A little  □ Somewhat  □ Very much so  □ Extremely

SECTION L: PHYSICAL ACTIVITY

1. To what extent do you enjoy physical activity? (Check one)
   □ Not at all  □ Slightly  □ Moderately  □ Greatly

2. Do you have any physical problems that limit your physical activity? □ Yes  □ No
   If yes, please describe. __________________________________________________________
   ________________________________________________________________________________
   ________________________________________________________________________________
3. Please check the types of physical activity that you have engaged in during the past six months.

- walking outside
- biking outside
- tennis/racket sports
- golf
- walking (indoors, including treadmill)
- biking (stationary)
- swimming
- dancing
- jogging/running
- aerobic class
- basketball
- strength training
- elliptical or other aerobic machine
- yoga
- other, Please describe _______________________

4. What is your most frequent physical activity? ________________________

   How many times per week do you engage in this activity? ______ times/week
   How many minutes per week do you engage in this activity? ______ minutes/week

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

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

7. How many hours of other “screen time” (e.g., computer, videos, games, etc.) do you engage in most days? (Do not count time spent on the computer at work.) _____ hours

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

9. How many flights of stairs do you climb up each day? _____ flights a day (1 flight = 10 steps)

10. Please describe your daily lifestyle activity (i.e., how active you are) by picking any number from 1 to 10 in which 1 = very sedentary and 10 = very active. Your number is: _____

SECTION M: FAMILY AND LIVING ARRANGEMENTS

1. I am currently: (Check one)
   - Single
   - Married/In committed relationship
   - Divorced
   - Separated
   - Widowed

2. Currently, I am: (Check all that apply)
   - living alone
   - living with a spouse
   - living with a partner/significant other
   - living with children
   - living with parents/step-parents
   - living with other relatives
   - living with roommates

3. Please indicate the total number of persons living in your home. ______

4. If you are currently involved in an intimate relationship (spouse/significant other), please answer these questions. What is this person’s attitude towards your efforts to lose weight? (Check one)

   - strongly supports my efforts
   - supports my efforts
   - neutral
   - opposes my efforts
   - strongly opposes my efforts

   Please describe briefly what this person does either to help or hinder your efforts to lose weight.
   ______________________________________________________________
   ______________________________________________________________
5. How satisfied are you with your overall relationship with this person? (Check one)
   □ very satisfied  □ satisfied  □ neutral  □ dissatisfied  □ very dissatisfied

6. Will other people support your efforts to lose weight? □ Yes  □ No
   If yes, who will support you? _______________________________________________________

7. Will other people oppose or undermine your efforts to lose weight? □ Yes  □ No
   If yes, who will undermine your efforts? ________________________________________________

SECTION N: SELF-PERCEPTIONS

1. How satisfied are you with your current weight? (Check one)
   □ very satisfied  □ somewhat satisfied  □ neutral  □ somewhat dissatisfied  □ very dissatisfied

2. How satisfied are you with your current overall appearance? (Check one)
   □ very satisfied  □ somewhat satisfied  □ neutral  □ somewhat dissatisfied  □ very dissatisfied

3. Pick the one sentence that best describes your overall feelings about yourself. “In general, I am…”
   (Check one)
   □ very happy with who I am  □ happy with who I am  □ ok with who I am but have some mixed feelings
   □ unhappy with who I am  □ very unhappy with who I am

4. “As compared with most people, I think I have…”
   (Check one)
   □ very good self-esteem  □ good self-esteem  □ average self-esteem  □ poor self-esteem
   □ very poor self-esteem

SECTION O: PSYCHOLOGICAL FACTORS

1. Have you ever had any problems anytime with depression, anxiety, or other emotions? □ Yes  □ No

2. Have you ever sought professional assistance for emotional problems? □ Yes  □ No
   If yes, specify below.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Year</th>
<th>Duration (wks.)</th>
<th>Type of Professional Help</th>
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</table>
3. Have you ever been hospitalized for a psychiatric condition? □ Yes □ No
If yes, describe below.

<table>
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<tr>
<th>Problem</th>
<th>Year</th>
<th>Duration (wks.)</th>
<th>Type of Professional Help</th>
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4. Have you ever tried to physically harm yourself? □ Yes □ No
If yes, describe below.

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

5. During the past month, have you felt depressed, sad, or blue much of the time? □ Yes □ No

6. During the past month, have you often felt hopeless about the future? □ Yes □ No

7. During the past month, have you had little interest or pleasure in doing things? □ Yes □ No

8. Have you ever been subjected to physical abuse? □ Yes □ No

9. Have you ever been subjected to sexual abuse? □ Yes □ No

SECTION P: TIMING

1. Please indicate if you are currently experiencing any greater than usual stress in your life related to the following events.
   Complete each item by checking the appropriate box.
   a. Work: □ Yes □ No
   f. Legal/financial trouble: □ Yes □ No
   b. Health: □ Yes □ No
g. School: □ Yes □ No
   c. Relationship with significant other: □ Yes □ No
   h. Moving: □ Yes □ No
d. Activities related to your children: □ Yes □ No
   i. Other: __________________
e. Activities related to your parents: □ Yes □ No

Please explain in a sentence any items to which you responded yes:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
2. Are you planning any major life changes (e.g., new job, moving, relationship, etc.) during the next 6 months? □ Yes □ No

   If yes, please briefly describe below:
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

3. How stressful has your life been during the past 6 months? (Check one.)
   □ much less stressful than usual
   □ less stressful than usual
   □ average level of stress
   □ more stressful than usual
   □ much more stressful than usual

4. How stressful do you think that your life will be in the next 6 months, excluding your efforts to lose weight? Pick a number from 1 to 5, in which 1 = much less stressful than usual and 5 = much more stressful than usual. _______

5. Why do you want to lose weight right now, as compared to 1 year ago? What has prompted you to lose weight now?
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

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

7. 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: _______
SECTION Q: MEDICAL HISTORY

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>Heart Disease</td>
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<tr>
<td>Angina (chest pains)</td>
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<td>Palpitations, heart beats fast or hard</td>
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<td>Stroke, mild stroke (cerebrovascular accident)</td>
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<td>Rheumatic fever</td>
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<td>Heart murmur</td>
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<td>Pacemaker</td>
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<tr>
<td>Breathing problems (asthma, lung disease)</td>
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<td>High blood pressure</td>
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<td>Anemia</td>
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<td>Back problems</td>
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<td>Joint or bone problems</td>
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<tr>
<td>Hiatal hernia</td>
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<tr>
<td>Arthritis</td>
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<tr>
<td>Gout (elevated uric acid)</td>
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<td>Gallbladder disease</td>
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<td>Thyroid problems</td>
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<td>Kidney disease</td>
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<td>Cancer (specify type)</td>
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<tr>
<td>Ulcers</td>
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<tr>
<td>Bowel disease</td>
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<td>Gastric Esophageal Reflux Disease (GERD)</td>
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<td>Liver disease</td>
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<tr>
<td>Diabetes (type I or II)</td>
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<td>Sleep Apnea</td>
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<td>Bodily pain</td>
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<td>Other (specify)</td>
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</table>
2. List all prescription medications you currently take. Please indicate the dosage and frequency (number of times a day) of each medication.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Reason for taking</th>
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Please indicate your primary care practitioner’s name, telephone number, and address here.

Name: _________________________________________________________ Tel: _____________________
Address: __________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

**ADDITIONAL INFORMATION** (Please use this space to provide any additional information that you think is important to understanding you or your weight problem, as well as the goals you seek.)

________________________________________________________________________________________
________________________________________________________________________________________
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