DEAN COMPREHENSIVE WEIGHT MANAGEMENT QUESTIONNAIRE

Today's Date______________________
Information Session_________ * Staff ONLY: ______

PLEASE INDICATE PROGRAM INTEREST:
Surgical Programs: LapBanding __________Gastric Bypass_________ Undecided __________

Medical Programs: LEARN__________ SMA____________ VLCD___________ Undecided ______

PERSONAL INFORMATION

Last Name _________________________________ First _____________________ MI ______

Address _______________________________ City ____________________ State _____ Zip ________
Telephone (home) (_____) ____________________ May we call you at home? YES NO
Telephone (work) (____) ____________________ May we call you at work? YES NO
Telephone (mobile (_____) ____________________ May we call your mobile? YES NO
E-Mail Address ___________________________DOB ___________ Current Age _____ Sex ______
Race ________________________ Marital Status ________________
Employer ______________________________ Phone ____________________ Occupation ________________
Do you have children living at home? YES NO
If yes, names and ages:

Emergency contact person (name): Primary telephone:
Relationship: Secondary telephone:
Primary Care Doctor:________________________________ Telephone (______)______________

Are you currently under the care of a physician or other health care provider? YES NO
If yes, explain. ____

What was the date of your last physical exam? ______________________

How did you hear about the Dean Comprehensive Weight Management Program?
____
____
____
____

SPOUSE OR PARENT INFORMATION

Last Name: __________________________________ First ______________________________ M.I. _________

Address _________________________________ City ______________________ State _____ Zip_________
Phone __________________________________ DOB ____________
Employer ______________________________ Phone ____________________ Occupation ________________

PLEASE SEE REVERSE SIDE FOR ADDITIONAL QUESTIONS

Dean HEALTH SYSTEM

INSURANCE/FINANCIAL INFORMATION

Insurance Company ____________________________ Policy # ____________________________

Insurance Phone # _____________________________ Policy Holder _______________________

Insurance Company ____________________________ Policy # ____________________________

Insurance Phone # ______________________________ Policy # ____________________________

If Dean Health Plan, how long has DHP been your insurance carrier? __________________

Federal Plan _________ State Plan __________ Private ___________ Dean Employee ______________

If you choose a weight loss treatment that includes supplements, meal replacement or very low calorie diet, will you be able to consistently make purchases of the supplements? YES NO
This is necessary with this treatment option.

Do you understand the costs associated with the Program? YES NO

Do you understand that insurance coverage is not guaranteed? YES NO

EDUCATION and OCCUPATION

Highest education level achieved:

Are you attending school now? YES NO If yes, FULL-TIME PART-TIME

Current occupation: _______________________________________ FULL-TIME PART-TIME

Employer: ____
Typical work hours: ____________________

Describe your work environment as it relates to your health and weight management (e.g. relationships, how active are you, access to food, etc.):

____
____
____
____
____
____
____

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HEALTH SYSTEM

FAMILY HISTORY

1. Have any of the following members of your family experienced problems with excess weight or eating disorders?

YES	NO	Member	None	Minor	Major	Description
☐	☐	Mother	☐	☐	☐	________________
☐	☐	Mother's parents	☐	☐	☐	________________
☐	☐	Father	☐	☐	☐	________________
☐	☐	Father's parents	☐	☐	☐	________________
☐	☐	Brothers	☐	☐	☐	________________
☐	☐	Sisters	☐	☐	☐	________________
☐	☐	Spouse	☐	☐	☐	________________
☐	☐	Children	☐	☐	☐	________________

	YES	NO
2. Are both parents living?	☐	☐
If no, list age and cause of death, if known. ______________________		

3. Do immediate family members have	YES	NO
High blood pressure: relationship ______________________________	☐	☐
Diabetes: relationship ______________________________________	☐	☐
Heart Disease: relationship ___________________________________	☐	☐
Kidney stone: relationship ___________________________________	☐	☐
Cancer: relationship ____	☐	☐
Thyroid Disease: relationship _________________________________	☐	☐
Have you or your family members had problems with anesthesia?	☐	☐

If yes, please explain ____

MEDICAL HISTORY

	YES	NO
1. Do you or have you ever had **heart disease**? Type: ______________________ Year diagnosed? _________	☐	☐
Are you still **under treatment**?	☐	☐
2. Do you frequently have **pains in your chest area**?	☐	☐
3. Is the **pain related to physical activity**? If, yes, explain.	☐	☐
4. Have you ever had **heart palpitations** (e.g. unusually rapid, strong or irregular heartbeat)? If yes, explain.	☐	☐
5. Do you often feel faint or have **spells of severe dizziness**?	☐	☐
6. If yes, do you **lose your balance or lose consciousness**.	☐	☐
7. Have you ever had a **stroke**? If yes, explain.	☐	☐

PLEASE SEE REVERSE SIDE FOR ADDITIONAL QUESTIONS

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HEALTH SYSTEM

	YES	NO
8. Has your doctor ever said you have **high blood pressure**? If yes, year diagnosis made? ___________ Medications: ______________________________	☐	☐
9. Has your doctor ever told you that you have a **bone or joint disease**, such as Arthritis, that has been aggravated by exercise or might be made worse with Exercise? If yes, circle involved joints and explain. low back hips knees ankles feet	☐	☐
10. Do you have **gout**?	☐	☐
11. Do you have or have you had **kidney stones**? If yes, explain.	☐	☐
12. Have you ever had **cancer**? If yes, explain.	☐	☐
13. Do you have **anemia**?	☐	☐
14. Do you often have **headaches**? If yes, explain.	☐	☐
15. Are you troubled with **constipation**? If yes, explain.	☐	☐
16. Do you consider yourself to be in **good physical and mental health**? If no, explain.	☐	☐
17. Have you ever had any **health problems as a result of dieting** or trying to lose weight? If yes, explain.	☐	☐
18. Do you have a history of **anorexia, bulimia, binge-eating disorder, compulsive overeating, Laxative/diuretic abuse, or any other eating disorder**? If yes, explain.	☐	☐
19. Have you ever **exercised excessively to lose weight**? If yes, explain.	☐	☐
20. Have you ever been treated for **stress, anxiety, depression or other psychiatric illness**?	☐	☐
A. If yes, what were your diagnoses? ______________________________		
B. Are you currently in treatment?	☐	☐
C. Have you had in an inpatient mental health hospitalization?	☐	☐
D. Do you have any history of psychosis?	☐	☐
21. Do you or have you ever had **drug addiction or recreational drug use**?	☐	☐
If yes, have you been in treatment?	☐	☐
22. Do you or have you ever had **alcoholism**?	☐	☐
If yes, have you been in treatment?	☐	☐
How much do you drink per day? ______ per week? ______		
23. Do you or have you ever had **diabetes**? Year diagnosed___________________ Medications ______________________________	☐	☐
24. Do you or have you ever been diagnosed with an **endocrine disorder** and/or **thyroid disease**? Year diagnosed ___________________	☐	☐

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	YES	NO
25. Do you or have you ever had **respiratory disease**? Diagnosis: ________________________Year diagnosis made __________	☐	☐
Are you still under treatment? Medications: ____	☐	☐
26. Do you or have you ever had symptoms of **sleep apnea**?	☐	☐
• Loud snoring?	☐	☐
• 30 second periods of not breathing while sleeping as observed by a family member?	☐	☐
• Elevation of head for improved breathing? How many pillows?____________	☐	☐
• Exhaustion with difficulty staying awake during daytime or while working?	☐	☐
• Are you currently on CPAP?	☐	☐
27. Do you or have you ever had **severe varicose veins/chronic swelling of the leg**?	☐	☐
28. Do you or have you ever had a history of **blood clots**? If yes, explain.	☐	☐
29. Do you or have you ever had **elevated cholesterol or triglycerides**? (Circle one and give levels, if known.) ______________________________	☐	☐
30. Do you or have you ever had **hiatal hernia or gastric reflux disease** (top of stomach pushing up into chest) causing frequent heartburn, especially at night? *You must enclosed documentation from a physician to support these conditions.*	☐	☐
31. If **gallbladder** not previously removed, any history of attacks (cholecystitis or gallstones) documented by x-ray or ultrasound? *Please circle and provide documentation*.		
32. Do you or have you ever had **peptic ulcer disease** (documented x-ray or endoscopy)?	☐	☐
33. Do you or have you ever had severe or chronic **rash under folds of loose skin**?	☐	☐
34. Do you or have you ever had **AIDS or positive HIV test**?	☐	☐
35. Has your physician ever told you that you are over weight and need to lose weight? If yes, explain.	☐	☐

36. Last appointment to see **eye doctor**? (name and date) ____

37. Last appointment to see **dentist**? (name and date) ____

Please describe any other major medical problems you have had in the past and treatment prescribed.

____

____

____

PLEASE SEE REVERSE SIDE FOR ADDITIONAL QUESTIONS

Dean HEALTH SYSTEM

PAST OPERATIONS (MAJOR)

Operation	Year	Hospital Location
____________________	________	____________________
____________________	________	____________________
____________________	________	____________________
____________________	________	____________________

Were there any surgical or anesthetic related complications? YES NO
If yes, please explain.

MEDICATIONS

Please list all medications that you are currently taking on a regular basis, including vitamins, minerals or other dietary supplements.

Name, dosage, frequency	Reason for Taking
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

KNOWN DRUG ALLERGIES:

Please list drug and type of reaction:____
____

Do you have a known Latex allergy? YES NO

SMOKING HISTORY:

1. Do you presently smoke?
   If, yes, please list number of packs per day. ______ YES NO
2. How many years have you smoked?
3. If you quit smoking, please state when.
4. How many years did you smoke before quitting?
   Average cigarettes smoked per day?

FOR WOMEN ONLY

	YES	NO
1. Do you have heavy urinary leakage (stress urinary incontinence)? If yes, please describe (i.e. frequency of pad use, only when cough or sneeze, etc.).	☐	☐
2. Menstrual abnormalities thought due to obesity?	☐	☐

Check all that apply
____irregular periods ____heavy periods ____amenorrhea (3 months or more between periods)

3. Obstetrical complications? YES NO
Check all that apply.
____toxemia ____high blood pressure ____gestational diabetes

PLEASE SEE REVERSE SIDE FOR ADDITIONAL QUESTIONS

Dean HEALTH SYSTEM

4. Time between periods? _______

5. Number of: ______ pregnancies ______ miscarriages
______ living births ______ premature births

6. Did any children weigh over 9 pounds at birth? YES NO

7. Date of last menstrual period? ____________________

8. When was your last pap smear? ___________________

7. Have you had a mammogram? YES NO
If yes , when? _________________

FOR MEN ONLY

Check all that apply.

______prostate trouble ______discharge from penis ______sore on penis
______lump in testicles ______difficulty having erections

other____
____

WEIGHT LOSS and DIETING HISTORY

Present weight ________ Height _______________

1. At what age did you first become overweight by 10 pounds or more?
2. If applicable, how long have you been at least 50 pounds over weight?
3. If applicable, how long have you been at lest 75 pounds over weight?
4. Have you ever has an operation for weight loss? YES NO

   If yes, when? __________________________ Surgeon's name: _____________________________

   Where?______________________________ What procedure?_____________________________
5. What is the lowest weight you have maintained for one year since you were 21 years old? ____________
   At what age? ___________
6. If applicable, what were you pre and post pregnancy weights for all children?
7. What is the most you have ever weighed? ______________ At what age? _____________
8. What was the longest time you kept weight off in your previous weight loss attempts? _____________
   How much weight did you keep off? ________________
9. What factors do you believe were important in helping you succeed in your prior weight loss efforts? Explain.____
   ____
10. What factors do you believe contributed to you gaining weight in the past? Explain.
    ____
    ____

PLEASE SEE REVERSE SIDE FOR ADDITIONAL QUESTIONS

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Please indicate which of the following diets or plans you have attempted:

PROGRAM	Dates	Duration	MD Supervised?	Weight Loss	Reason Stopped
Atkins Diet					
Grapefruit Diet					
Herbalife					
Jenny Craig					
LA Weight Loss					
Liquid Diets					
Medifast					
Metabolife					
Nutri/System					
OptiFast					
Overeaters Anonymous					
Pritikin Diet					
Seattle Suttens					
Slim Fast / Other Meal Replacement					
South Beach Diet					
T.O.P.S.					
Weight Watchers					
Other Fad Diet					

When participating in other weight loss programs, did you keep food records? YES NO

If yes, why did you stop keeping records? ________________________________

____

____

____

PLEASE SEE REVERSE SIDE FOR ADDITIONAL QUESTIONS

Dean HEALTH SYSTEM

WEIGHT LOSS MEDICATION HISTORY

Please indicate if you have taken any of the following medications to lose weight.

MEDICATION	Dates	Duration	MD Supervised?	Weight Loss	Reason Stopped
Amphetimines					
Dexfenfluramine (Redux)					
Meridia (Sibutramine)					
Phen-Fen					
Phentermine (Adipex, Fastin, Pondimin)					
Xenical (Orlistat)					
Other Diet Medications:					

List any physician supervised weight loss attempts including medications (Please list physicians name, address and dates you were under his/her care.)

____

____

____

NON-DIETARY WEIGHT LOSS THERAPIES

THERAPY	Dates	Duration	MD Supervised?	Weight Loss	Reason Stopped
Exercise					
Hypnosis					
Behavior Modification					
Acupuncture					

List any other weight loss methods you have tried:

____

____

____

____

PLEASE SEE REVERSE SIDE FOR ADDITIONAL QUESTIONS

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EATING QUESTIONNAIRE

For each of the questions below, circle the answer that best describes your response for the last six months. After you have circled your response, place the corresponding number of that response on the line at the beginning of each question.

_____1. Which of the following responses best describe your overall eating pattern(s):

0 I never have trouble overeating. (If you circle "0" for this statement, skip to question 7. Overeating does not appear to be a problem for you.)
1 I sometimes feel that I eat too much during particular eating episodes. (If you circle "1" for this statement, skip to question 7. Overeating does not appear to be a problem for you.)
2 I sometimes eat within a two-hour period what I and most people would consider an unusually large amount of food.
3 I quite often eat within a two-hour period what I and most people would consider an unusually large amount of food.

_____ 2. If you scored a 2 or 3 to Question 1 above, when you eat this way (a large amount of food at one time), how often do you feel like you cannot stop eating or control what or how much you eat?

0 Never
1 Rarely
2 Occasionally
3 Most of the time
4 Always

_____ 3. If you scored 2, 3 or 4 to Question 2 above, how certain are you that you could control these episodes of eating?

0 Extremely certain
1 Quite certain
2 Somewhat certain
3 Slightly certain
4 Not at all certain

_____4. If you scored a 2 or 3 to Question 1 above, how do you feel when this type of eating takes place? Place a check mark beside the statement(s) below that best describe your feelings. (You may check more than one statement.)

______ My eating is more rapid than usual.
______ I eat until I feel uncomfortably full.
______ The eating occurs when I am not feeling physically hungry.
______ When I experience this eating behavior, I do it alone because I am embarrassed by the amount of food I eat.
______ After my eating episode, I feel disgusted with myself, depressed or guilty from overeating.

Count the number of statements above that you marked with a check and circle the number below. Place that number on the line in front of #4.

0 Less than two statements checked.
1 Two statements checked.
2 Three or more statements checked.

PLEASE SEE REVERSE SIDE FOR ADDITIONAL QUESTIONS

_____ 5. If you scored a 2 or 3 to Question 1 above, how often have you engaged in this type of eating behavior over the last six months?

1 Less than once a month
2 Once a month to a few times a month
3 A few times a month to two (2) times a week
4 Two (2) times a week
5 Daily

_____6 If you scored a 2, 3 or 4 to Question 2 above, how upset were you that you were unable to control what or how much you were eating?

1 Not at all upset
2 Slightly upset
3 Somewhat upset
4 Quite upset

_____ TOTAL for Questions 1 – 6.

_____ 7. Have you ever purged (used laxatives, diuretics or induced vomiting) to control your weight?

1 Yes
2 No

_____ 8. If your answer to Question 7 above was yes, how often have you engaged in this purging behavior during the past six months?

1 Less than once a month
2 About once a month to a few times a month
3 A few times a month to two (2) times a week
4 Two (2) times a week
5 Daily

_____ TOTAL for questions 7 – 8

_____ 9. Place a mark beside the statement(s) below that apply to you on a routine basis. (You may check more than one statement.)

______ I skip meals and/or attempt to not eat for long periods of time.
______ I set very specific calorie goals and feel upset when I cannot meet them.
______ I regularly try to avoid certain types of food because of concern that they will either negatively influence my weight or shape or because they might trigger a binge eating episode.
______ I regularly try to avoid certain social situations that might involve eating.

Give yourself one (1) point for each statement that you checked.

_____ 10. Which of the following statements best describes your feelings when you are dieting to lose weight and *break* your diet by eating *forbidden food*?

0 I learn from experience and keep on my diet without feeling guilty.
1 Sometimes I feel bad and eat a little more, but I can see the progress I've made and get back on my diet.
2 Frequently when this happens, I think to myself, "I've blown it now," and eat even more.
3 It seems like I am always on a diet, and when I overeat I go off the diet because I continue to overeat. Later I start another strict dieting regime only to find myself overeating again.

PLEASE SEE REVERSE SIDE FOR ADDITIONAL QUESTIONS

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_____ 11. Place a check mark beside the statement(s) below if they apply to you.
(*You may check more than one statement*.)

______ My binge eating negatively influences how I feel about myself as a person.
______ When I feel unable to effectively diet or control my weight, I feel my self-worth is diminished.
______ My weight and/or my body shape are among the most important attributes that I have. (e.g. My weight or shape is more important to me than most anything else.)

Give yourself one point for each statement you checked and write that number on the line next to number 11.

_____ TOTAL for Questions 9 – 11.

NUTRITIONAL ASSESSMENT

1. To the best of your recollection, at what age did your weight become a problem for you? _________

2. What life events have been associated with a significant weight change? *Check all that apply*.

_____ Quit smoking
_____ Medications
_____ Retirement
_____ Marriage
_____ Relationship breakup/ divorce
_____ New job
_____ Illness in family
_____ Other ____

3. Are you currently following any of these diet modifications?

_____ Low cholesterol
_____ Diabetic
_____ Weight Reduction
_____ Carb counting
_____ Low fat
_____ Vegetarian
_____ Vegan
_____ Lactovegetarian
_____ Lactoovovegetarian
_____ Sodium restriction
_____ Other ____

4. Is any member of your household on a diet? YES NO
If yes, describe. ____

5. Do you have any food allergies or intolerances? YES NO
If yes, explain. ____

6. Do you have any religious practices or beliefs that influence your food choices? YES NO
If yes, explain. ____

7. If there are two things you feel you want to change about what you eat or how you eat, what would they be?
____

8. Please check yes or no if the following statements apply to you.

	YES	NO
I eat the same things from day to day.	☐	☐
My diet is chaotic and variable.	☐	☐
I eat very differently on weekends compared to weekdays.	☐	☐
I graze all day.	☐	☐
I eat one or two large meals per day.	☐	☐
I usually skip breakfast.	☐	☐
I eat at bedtime.	☐	☐
I eat in the middle of the night.	☐	☐

PLEASE SEE REVERSE SIDE FOR ADDITIONAL QUESTIONS

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9. If I snack, these are the foods I usually pick: ______________________________

10. Which of the following beverages do you consume on a daily basis and how much?

Coffee – reg or decaf (circle one or both)	__________	cups
Tea	__________	cups
Milk (skim, 1%, 2%, whole, chocolate)	__________	cups
Fruit juice	__________	cups
Soda diet or regular (circle one)	__________	ounces
Water	__________	ounces

11. How many times do you eat in a restaurant per week? Breakfast _____ Lunch _____ Dinner _____
List restaurants where you often eat. ______________________________
____

12. Do you drink alcohol? YES NO
If yes, how often do you drink?
_____Daily Type and amount ____________________
_____Weekly Type and amount ____________________
_____Monthly Type and amount ____________________
_____ I rarely drink alcohol.

13. These are the times I eat even though I am not hungry. (Check all that apply to you.)

____	Bored	____	Fearful	____	Worried
____	Tired	____	Studying	____	Watching TV
____	Meeting with friends	____	Attending meetings	____	Working at my computer
____	Reading	____	Just because it's there (such as snacks at work)		

14. How many people are in your household? ______________________________

15. Who prepares your meals? ______________________________

16. Who shops for groceries? ______________________________

17. Do you read labels? YES NO
If yes, what do you look for on labels? ______________________________

18. Do you plan your list or shop at the spur of the moment? YES NO

19. Do you plan meals? YES NO

20. Do you eat with others or by yourself most of the time? ______________________________

21. Where do you usually or often eat?

____	Dining table	____	In front of TV or computer
____	Standing up or on the run	____	In my car
____	Other ______________________________		

	YES	NO
22. Do you eat faster than those around you?	☐	☐
23. Do you know when you are full?	☐	☐

PLEASE SEE REVERSE SIDE FOR ADDITIONAL QUESTIONS

Dean HEALTH SYSTEM

	YES	NO
24. Can you tell the difference between physical hunger and emotional hunger?	☐	☐
25. Do you often eat large amounts of food when you are not feeling hungry?	☐	☐
26. Do you eat alone because you are embarrassed by how much you eat?	☐	☐
27. Do you feel disgusted, depressed or guilty after overeating?	☐	☐
28 Do you feel you don't have control to stop eating?	☐	☐
29. Do you have food cravings? If yes, what? ______________________________	☐	☐
30. Do you have any specific questions about diet and nutrition? If yes, what are they? ______________________________	☐	☐
31. Do you have time constraints or financial constraints that affect how you eat? If yes, explain. ______________________________	☐	☐
32. Have you ever worked with a dietitian?	☐	☐
33. Do you usually eat when hungry?	☐	☐

34. How often do you weigh yourself? ____________________

35. Describe your eating pattern:

___ Eat three meals a day
___ Skip meals
___ Binge without vomiting
___ Binge followed by exercise
___ Vomit without bingeing
___ Use laxatives without bingeing
___ Eat three meals a day with snacks
___ Restrict intake of foods
___ Binge followed by vomiting
___ Binge followed by diuretics/water pills/diet pills
___ Restrict food intake without bingeing

36. Are you happy with your pattern of eating? YES NO
If not, what do you want to change?

____
____
____

PHYSICAL ACTIVITY ASSESSMENT

		YES	NO
1.	Are you currently **physically active on a regular** (i.e. most days of the week) basis? If yes, explain the type of activity that you do.	☐	☐
2.	Is there any reason not mentioned here why you believe that you **should not engage in physical activity** even if you wanted to? If yes, explain.	☐	☐

PLEASE SEE REVERSE SIDE FOR ADDITIONAL QUESTIONS

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		YES	NO
3.	Do you have a bone or joint problem that could be made worse by a change in your physical activity?	☐	☐
4.	Have you been physically active during the past 3 – 6 months? If yes, what activities have you been doing and how often?	☐	☐
5.	Was there a time in you past when you were physically active on a regular basis? If yes, when and what did you do?	☐	☐
6.	Have you ever participated in sports or organized exercises (e.g. aerobic classes)? If yes, what were they and when did you participate?	☐	☐
7.	Do you want to become for physically active on a regular basis?	☐	☐
8.	Do you have any concerns about becoming more physically active now? If yes, what are your concerns?	☐	☐

9. What gets in the way of you being physically active? ______________________________________

10. What types of exercise and physical activity do you enjoy enough to do again? ___________________

SELF IMAGE / AFFECT

The following questions pertain to body image and its link with food and weight. For each of the following statements, score as follows:

0 = NEVER 1 = SELDOM 2 = OCCASIONALLY 3 = ALWAYS

_____ My family and friends say I look good but I don't believe them
_____ My weight determines how I fell about myself.
_____ I'm pre-occupied with "feeling fat".
_____ I get on a scale daily.
_____ When I discover I have gained a pound, I panic.
_____ If I cannot exercise to burn off calories, I panic.
_____ My weight prevents me from accomplishing other goals in my life.
_____ I avoid mirrors and reflections.
_____ I hide my body in loose clothing.
_____ I feel depressed when I look through fashion magazines.
_____ I feel self conscious around thin people.
_____ I do not wear a bathing suit in public.
_____ I diet to lose weight.
_____ I'm obsessed with reading books about dieting and weight control.
_____ I avoid social events because of my weight.
_____ I divide food into two categories: "good" and "bad".
_____ When I eat "bad" foods, I label myself as a bad person.
_____ I feel out of control with my food.
_____ I dislike my body.

PLEASE SEE REVERSE SIDE FOR ADDITIONAL QUESTIONS

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When answering the questions below, think about whether the problem has lasted for at least two weeks consecutively, during which it negatively affected several aspects of your life (e.g. family, work, etc.).

		YES	NO
1.	Do you find yourself so sad and depressed that it colors your entire life and you can't seem to escape from it?	☐	☐
2.	Do you find yourself not enjoying anything anymore?	☐	☐
3.	Do you have trouble concentrating on most tasks (e.g. working, reading, etc.)?	☐	☐
4.	Do you have little energy and feel like you need to struggle to do anything at all?	☐	☐
5.	Have your sleeping patterns changed (e.g. have trouble falling asleep, wake up frequently during the night, wake up early in the morning, and despite being tired, can not fall back to sleep, or find yourself sleeping much more than usual)?	☐	☐
6.	Do you feel increasingly guilty, worthless and hopeless?	☐	☐
7.	Have you experienced a change in your eating patterns (i.e. poor appetite or over eating)?	☐	☐

WEIGHT LOSS READINESS

1. Record in the space below, your scores from the Weight Loss Readiness Test II:

___________ Category 1: Motivation

___________ Category 2: Expectations

___________ Category 3: Confidence

___________ Category 4: Hunger and Eating Cues

___________ Category 5: Binge Eating and Purging

___________ Category 6: Emotional Eating

2. What has made you decide to lose weight now?

3. What factors are present now that you believe will help you succeed at losing weight?

4. What factors are present now that you believe will make losing weight difficult?

5. What would be the benefits of losing weight now?

6. What would be the costs/sacrifices of losing weight now?

7. What barriers might get in the way of you increasing your physical activity by 30 – 60 minutes each day?

PLEASE SEE REVERSE SIDE FOR ADDITIONAL QUESTIONS

Dean
HEALTH SYSTEM

8. Is there anything going on in your life right now (or coming up in the next few months) that may make it difficult for you to spend time reading, completing homework assignments or being more physically active? YES NO
   If yes, then explain? ____

9. What do you consider to be your "ideal" body weight? _________

10. What is your desired weight? ___________

11. When were you last at that weight? _________

PATIENT AFFIRMATION STATEMENT

I, ____, do hereby attest, certify and affirm that the information I have provided in these program assessment/questionnaire forms, including all medical information, is complete and accurate to the best of my knowledge. I agree to accept complete responsibility for omissions regarding my failure to disclose existing or past health conditions and understand that is will be considered non-compliance and grounds for discharge from the Comprehensive Weight Management Program. I also understand that there are certain conditions including mental health diagnoses and history that may exclude me from eligibility.

____ ___________________________
Patient Signature Date

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The Weight Loss Readiness Test II

Answer the questions below to see how well your attitudes and current behaviors equip you for a weight loss program. For each question, circle the number that best describes your attitude, then write the number of your answer on the line before each question number. As you complete each of the six categories, add the numbers of your answers and compare them with the scoring guide at the end of this test.

Category 1: Motivation

____ 1. Compared to previous attempts, how motivated are you to lose weight this time?

0 Not at all motivated
1 Slightly motivated
2 Somewhat motivated
3 Quite motivated
4 Extremely motivated

____ 2. Compared to previous attempts, how motivated are you to change your eating habits this time?

0 Not at all motivated
1 Slightly motivated
2 Somewhat motivated
3 Quite motivated
4 Extremely motivated

____ 3. Compared to previous attempts, how motivated are you to increase your physical activity this time?

0 Not at all motivated
1 Slightly motivated
2 Somewhat motivated
3 Quite motivated
4 Extremely motivated

____ 4. How motivated are you to stay committed to a weight loss program for the time it will take to reach your weight loss goal?

0 Not at all motivated
1 Slightly motivated
2 Somewhat motivated
3 Quite motivated
4 Extremely motivated

____ 5. How motivated are you to try new strategies/techniques for changing your eating, exercise, and other behaviors?

0 Not at all motivated
1 Slightly motivated
2 Somewhat motivated
3 Quite motivated
4 Extremely motivated

_____ Category 1—TOTAL Score

Category 2: Expectations

____ 6. Think honestly about how much weight you hope to lose and how quickly you hope to lose it. Figuring a weight loss of one to two pounds per week, how realistic is your expectation?

0 Very unrealistic
1 Somewhat unrealistic
2 Moderately unrealistic
3 Somewhat realistic
4 Very realistic

____ 7. How satisfied would you be if you achieved a 10% weight loss?

0 Not at all satisfied
1 Slightly satisfied
2 Somewhat satisfied
3 Quite satisfied
4 Extremely satisfied

____ 8. If you achieved a 10% weight loss that significantly improved your health, how satisfied would you be?

0 Not at all satisfied
1 Slightly satisfied
2 Somewhat satisfied
3 Quite satisfied
4 Extremely satisfied

____ 9. If you achieved a 10% weight loss that significantly improved your quality of life, how satisfied would you be?

0 Not at all satisfied
1 Slightly satisfied
2 Somewhat satisfied
3 Quite satisfied
4 Extremely satisfied

_____ Category 2—TOTAL Score

Category 3: Confidence

When answering questions 10 through 17, consider all outside factors at this time in your life (the stress you're feeling at work and/or home, your obligations, etc.).

____ 10. People who want to achieve long-term weight control need to spend time every day trying to change their eating, exercise, and thinking habits. You probably know the time and commitment necessary for you to be successful. How confident are you that you can devote this amount of effort, both now and over the next few months?

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0 Not at all confident
1 Slightly confident
2 Somewhat confident
3 Quite confident
4 Extremely confident

____ 11. How confident are you that you will be able to attend program meetings regularly or (if you're not in a formal program) follow your own program regularly?

0 Not at all confident
1 Slightly confident
2 Somewhat confident
3 Quite confident
4 Extremely confident

____ 12. How confident are you that you will be able to record everything you eat and drink, and your exercise, most days of the week?

0 Not at all confident
1 Slightly confident
2 Somewhat confident
3 Quite confident
4 Extremely confident

____ 13. How confident are you that you will be able to change your eating habits?

0 Not at all confident
1 Slightly confident
2 Somewhat confident
3 Quite confident
4 Extremely confident

____ 14. How confident are you that you will be able to work regular physical activity into your daily schedule?

0 Not at all confident
1 Slightly confident
2 Somewhat confident
3 Quite confident
4 Extremely confident

____ 15. How confident are you that you will be able to exercise at least five days per week, most weeks?

0 Not at all confident
1 Slightly confident
2 Somewhat confident
3 Quite confident
4 Extremely confident

____ 16. How confident are you that you will be able to maintain your healthy eating habits for one year or longer?

0 Not at all confident
1 Slightly confident
2 Somewhat confident
3 Quite confident
4 Extremely confident

____ 17. How confident are you that you will be able to continue exercising regularly (at least five days per week) for one year or longer?

0 Not at all confident
1 Slightly confident
2 Somewhat confident
3 Quite confident
4 Extremely confident

_____ Category 3—TOTAL Score

Category 4: Hunger and Eating Cues

____ 18. When food comes up in conversation or in something you read, do you want to eat even if you are not hungry?

0 Never
1 Rarely
2 Occasionally
3 Frequently
4 Always

____ 19. How often do you eat because of physical hunger?

0 Always
1 Frequently
2 Occasionally
3 Rarely
4 Never

____ 20. Do you have trouble controlling your eating when your favorite foods are around the house?

0 Never
1 Rarely
2 Occasionally
3 Frequently
4 Always

_____ Category 4—TOTAL Score

Category 5: Binge Eating and Purging

____ 21. Aside from holiday feasts, have you ever eaten a large amount of food rapidly and felt afterward that this eating incident was excessive and out of control?

2 Yes
0 No

____ 22. If you answered yes to question 21 above, how often have you engaged in this behavior during the last year?

0 Less than once a month
1 About once a month
2 A few times a month
3 About once a week
4 About three times a week
5 Daily

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____ 23. Have you ever purged (used laxatives, diuretics, or induced vomiting) to control your weight?

3 Yes
0 No

____ 24. If you answered yes to question 23, how often have you engaged in this behavior during the last year?

0 Less than once a month
1 About once a month
2 A few times a month
3 About once a week
4 About three times a week
5 Daily

_____ Category 5—TOTAL Score

Category 6: Emotional Eating

____ 25. Do you eat more than you would like to when you have negative feelings, such as anxiety, depression, anger, or loneliness?

0 Never
1 Rarely
2 Occasionally
3 Frequently
4 Always

____ 26. Do you have trouble controlling your eating when you have positive feelings—do you celebrate feeling good by eating?

0 Never
1 Rarely
2 Occasionally
3 Frequently
4 Always

____ 27. When you have unpleasant interactions with others in your life, or after a difficult day at work, do you eat more than you would like?

0 Never
1 Rarely
2 Occasionally
3 Frequently
4 Always

_____ Category 6—TOTAL Score

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The Weight Loss Readiness Test II—Scoring

Category 1: Motivation

If you scored:

0 to 6 — This may not be a good time for you to start a weight loss program. Inadequate motivation could block your progress. Think about the things that contribute to this, and consider changing them before undertaking a weight loss program.

7 to 14 — You may be close to being ready to begin a weight loss program but should think about ways to increase your motivation before you begin.

15 to 20 — The path is clear with respect to your motivation.

Category 2: Expectations

If you scored:

0 to 5 — Your expectations for weight loss are unrealistic. If you do not achieve your weight loss goals, you will probably be very disappointed. Think about your reasons for losing weight, and try to set more realistic goals.

6 to 11 — Your expectations may be a bit high. Try to focus on other reasons for changing your eating and exercise behavior, besides just the numbers on the scale.

12 to 16 — Your expectations are right on target.

Category 3: Confidence

0 to 12 — This may not be a good time for you to start a weight loss program. You may want to wait until you feel more confident in your ability to change your behavior.

13 to 23 — You may be close to being ready to begin a weight loss program but should think about ways to boost your confidence before you begin.

24 to 32 — Your confidence in your ability to change your behavior is strong.

Category 4: Hunger and Eating Cues

If you scored:

0 to 3 — You might occasionally eat more than you would like, but it does not appear to be a result of high responsiveness to external cues. Controlling the attitudes that make you eat may be especially helpful.

4 to 6 — You may have a moderate tendency to eat just because food is available. Weight loss may be easier for you if you try to resist external cues, and eat only when you are physically hungry.

7 to 12 — Some or most of your eating may be in response to thinking about food or exposing yourself to temptations to eat. Think of ways to minimize your exposure to temptations, so that you eat only in response to physical hunger.

Category 5: Binge Eating and Purging

If you scored:

0 to 2 — It appears that binge eating and purging is not a problem for you.

3 to 5 — Pay attention to these eating patterns. If they interfere with your life or concern you, see a professional. Definitely see a professional if they get worse.

6 to 15 — Be aware of potentially having a serious eating problem, particularly if your score is high in this range and the problems are current. In this case, see a counselor experienced in evaluating and treating eating disorders.

Category 6: Emotional Eating

If you scored:

0 to 5 — You do not appear to let your emotions affect your eating.

6 to 8 — You sometimes eat in response to emotional highs and lows. Monitor this behavior to learn when and why it occurs, and be prepared to find alternative activities.

9 to 12 — Emotional ups and downs can stimulate your eating. Try to deal with the feelings that trigger the eating, and find other ways to express them.

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