Initial Evaluation Questionnaire

Reason for Weight Center Referral: .................................................................
.........................................................................................................................

Patient Goals and Expectations
What are you expecting from treatment? ...........................................................
.........................................................................................................................

Are you interested in a specific type of treatment (e.g., surgery, nutrition education, medications)?
.........................................................................................................................

Your Weight History

Please indicate how large you were during each of the following age ranges:

Early Childhood (up to 6 years old):
☐ underweight  ☐ average weight  ☐ overweight  ☐ very overweight

Late Childhood (6 years to puberty)
☐ underweight  ☐ average weight  ☐ overweight  ☐ very overweight

Adolescence (about 12 through 18 years old)
☐ underweight  ☐ average weight  ☐ overweight  ☐ very overweight

Family History of Obesity: check all that apply
☐ mother has obesity
☐ father has obesity
☐ one or more of my brothers and sisters have obesity
☐ one or more of my children have obesity

Triggers of weight gain: In your opinion, which factors are the most important causes of your weight gain?

☐ Pregnancy  ☐ Stopping smoking  ☐ Family history of obesity

☐ Change in activity level (describe): .................................................................

☐ Emotional factors (describe): .........................................................................

☐ Medicines (describe): ....................................................................................

☐ Other events or factors (describe): .................................................................

Please answer the following questions regarding your lifestyle:
On average I get ____ hours of sleep per night.
My work hours are: _____________________________
**Prior Weight Loss Efforts**

I started dieting at age: 

Have you lost weight and regained weight many times? □ yes □ no □ sometimes

After losing weight do you gain even more back? □ yes □ no □ sometimes

**Diet History:** Below is a list of different diet programs. Please indicate which of these methods you have tried, if any:

<table>
<thead>
<tr>
<th>DIET OR PROGRAM</th>
<th>What age were you when you first tried this diet?</th>
<th>Number of times on this diet</th>
<th>How much weight did you lose the first time?</th>
<th>How much weight did you lose the second time?</th>
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<tbody>
<tr>
<td><strong>Commercial Programs:</strong></td>
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<td>TOPS</td>
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<tr>
<td>Weight Watchers</td>
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<tr>
<td>Jenny Craig</td>
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<tr>
<td>NutriSystem</td>
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<tr>
<td>Ideal Protein</td>
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<tr>
<td>Other (please list)</td>
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<tr>
<td><strong>Medically Supervised Liquid Diets:</strong></td>
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<td>Optifast / HMR / other</td>
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<td><strong>Medication(s):</strong></td>
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<tr>
<td>Phen/fen; Redux</td>
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<td>Meridia</td>
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<tr>
<td>Orlistat</td>
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<td>Other (please give name of drug)</td>
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<tr>
<td><strong>Behavior Modification programs</strong></td>
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<tr>
<td>run at a hospital or with a dietitian</td>
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<td>or behaviorist</td>
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<tr>
<td>Other (please be specific)</td>
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<tr>
<td>Overeaters Anonymous, self-directed</td>
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<tr>
<td>diets, diet books, etc:</td>
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</tbody>
</table>
Nutrition and Eating Habits

1. Household Members:

Please list all members of your household and their relationship to you

2. Which family member(s) is responsible for grocery shopping?

☐ yourself     ☐ spouse/partner     ☐ Other: ..................

3. Which family member(s) are responsible for cooking?

☐ yourself     ☐ spouse/partner     ☐ Other: ..................

4. Overall, when do you eat most of your food?

☐ At meals     ☐ In snacks     ☐ Both     ☐ Varies

5. If at meals, then which meal is the largest?

☐ Breakfast     ☐ Lunch     ☐ Dinner

6. If in snacks, then when are the largest snacks?

☐ Morning     ☐ Afternoon     ☐ Nighttime

How often do you usually have a meal in each of these types of restaurants?

Fast food – e.g., McDonald’s, Burger King, Taco Bell, etc.

☐ Never     ☐ Less than 1 time/week     ☐ 1 time/week     ☐ 2-3 times/week     ☐ 4 or more/week

Primary reason for use:     ☐ Business     ☐ Social     ☐ Convenience

Moderately-priced restaurants

☐ Never     ☐ Less than 1 time/week     ☐ 1 time/week     ☐ 2-3 times/week     ☐ 4 or more/week

Primary reason for use:     ☐ Business     ☐ Social     ☐ Convenience

High-priced restaurants

☐ Never     ☐ Less than 1 time/week     ☐ 1 time/week     ☐ 2-3 times/week     ☐ 4 or more/week

Primary reason for use:     ☐ Business     ☐ Social     ☐ Convenience

Take-out food – e.g., Pizza, subs, Chinese food, etc.

☐ Never     ☐ Less than 1 time/week     ☐ 1 time/week     ☐ 2-3 times/week     ☐ 4 or more/week
How often do you usually have any of these beverages?

- **Juice**
  - None
  - 1-2 servings / DAY
  - 3-5 servings /DAY
  - 6+ servings / DAY

- **Soda (non diet)**
  - None
  - 1-2 servings / DAY
  - 3-5 servings /DAY
  - 6+ servings / DAY

- **Soda (diet)**
  - None
  - 1-2 servings / DAY
  - 3-5 servings /DAY
  - 6+ servings / DAY

- **Coffee and/or tea**
  - None
  - 1-2 servings / DAY
  - 3+ servings /DAY
  - 6+ servings / DAY

- **Fruit smoothies**
  - None
  - 1-2 servings / DAY
  - 3+ servings /DAY
  - 6+ servings / DAY

**Milk-based drinks** (latte, Frappucino, etc.)
- None
  - 1-2 servings / DAY
  - 3+ servings /DAY
  - 6+ servings / DAY

How often did you have a drink containing **alcohol** in the past YEAR?
- Never
- Monthly or less
- Once a week
- 2-4 times per WEEK
- 4 or more times per WEEK

In the past YEAR, on a **typical** day when you were drinking, how many drinks would you have?
- None, I don't ever drink alcohol
- 1
- 2
- 3
- 4
- 5-6
- 7-9
- 10 or more

In the past YEAR, how often did you have 5 or more drinks on one occasion?
- Never
- Less than monthly
- Monthly
- Weekly
- 2-4 times weekly
- Daily

**Cigarette use**
- None
- 1/2 pack/day or less
- 1-2 pack/day
- More than 1 pack/day
- I quit smoking ______ years ago

Do you have any **Food allergies/intolerances**?
If yes, please list:

List any **Dietary or Vitamin/mineral Supplements** you take daily:

**Physical Activity Patterns**
Do you do any regular exercise, including walking to/from work/school, walking dog, etc.?
- Yes
- No

If Yes, what type of exercise do you do?
How many minutes at a time do you typically do this exercise for?
How many days a week do you do this exercise?

**How would you describe your activity during a typical day at work or home? (circle one)**
- SEDENTARY (sit most of day)
- ACTIVE (on my feet most of day)
- VERY ACTIVE (lifting, walking, on feet all day, construction)
Personal History

The following information will help us understand the supports, stresses, and obligations in your life. If you choose, you may skip any questions or topics.

Your Family:

Spouse or Partner:
- □ Never married
- □ Married
- □ Cohabitating
- □ Separated
- □ Divorced
- □ Widowed
- □ Remarried (e.g., 2\textsuperscript{nd}, 3\textsuperscript{rd} marriage)

Children: Do you have any children?:
- □ Yes
- □ No

If yes, please give the following information:

<table>
<thead>
<tr>
<th>Age/gender of child</th>
<th>Is he or she living with you?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes □ No</td>
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<tr>
<td>□ Yes □ No</td>
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<td>□ Yes □ No</td>
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<td>□ Yes □ No</td>
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<tr>
<td>□ Yes □ No</td>
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</tbody>
</table>

Education:
1. What is the highest grade or year of school you completed:
   - □ 8\textsuperscript{th} grade or less
   - □ Some high school, did not finish
   - □ Graduated high school or earned GED
   - □ Vocational, trade, or technical school
   - □ Started but did not complete college
   - □ Graduated from two-year college
   - □ Graduated from four-year college
   - □ Started post-college degree (e.g., Master’s, PhD, etc.)
   - □ Finished post-college degree

2. If you are currently a student, do you attend classes:
   - □ Part time
   - □ Full time

Employment:
1. Which of the following best describes your occupational status?
   - □ Currently employed
   - □ Full time
   - □ Part time - Please list occupation/job title: __________________________
   - □ Disabled
     - □ If disabled, please state what year this began, and reason for disability: __________________________
   - □ Retired
   - □ Unemployed
   - □ Student
   - □ Stay-at-home parent/homemaker
   - □ Volunteer (Describe: __________________________)
   - □ Other (Describe: __________________________)
Your Mental Health History:

Have you ever had symptoms of or been diagnosed with any of the following illnesses?

<table>
<thead>
<tr>
<th>Illness</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
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</thead>
<tbody>
<tr>
<td>Anorexia nervosa</td>
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<tr>
<td>Bulimia nervosa</td>
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<tr>
<td>Binge-eating disorder</td>
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<tr>
<td>Other type of eating disorder</td>
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<tr>
<td>If so, what type?</td>
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<td>Learning disability:</td>
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<td>If so, what type?</td>
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<tr>
<td>Personality disorder:</td>
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<td>If so, what type?</td>
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<tr>
<td>Depression:</td>
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<td>Bipolar disorder (manic-depression):</td>
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<td>Anxiety disorder:</td>
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<td>If so, what type?</td>
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<tr>
<td>Panic attacks:</td>
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<tr>
<td>Phobia(s):</td>
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<tr>
<td>Obsessive-compulsive disorder:</td>
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<tr>
<td>Posttraumatic stress disorder:</td>
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<tr>
<td>Schizophrenia or schizoaffective disorder:</td>
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<tr>
<td>Alcohol dependence or abuse:</td>
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<td></td>
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<tr>
<td>Drug dependence or abuse:</td>
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<tr>
<td>Other type of emotional problem or mental illness:</td>
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<tr>
<td>If so, what type(s)?</td>
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</table>

Have you ever intentionally injured yourself?  
If so, when and how?  

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<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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Have you ever tried to kill yourself?  
If so, when and how?  

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<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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Have you ever intentionally injured someone else?  
If so, when and how?  

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<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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Mental Health Treatment:  
1. Are you currently seeing a therapist?  
   Yes  No  

If YES, please list this provider's name and telephone number:

Name: .................................................................  Telephone: .................................
2. Have you ever received mental health therapy or counseling in the PAST?  □ Yes  □ No
If YES, please list the approximate dates of treatment, provider’s name, and reason for treatment

Dates of Treatment ____________________________ Clinician’s name ____________________________ Reason(s) for treatment ____________________________

3. Are you currently taking any psychiatric medications (e.g., antidepressants, medications for anxiety, etc)?

□ Yes  □ No
If YES, please be sure to list these medications on the medications list on page 8

If YES, please list the name and telephone number of the provider who prescribes these medications

Name: .......................................................... Telephone: ...........................................

Have you ever received medication for emotional problems or mental illness in the PAST?  □ Yes  □ No
If yes, please list the names of all of the mental health medications you have taken in the past:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

4. Have you ever been hospitalized for psychiatric reasons?  □ Yes  □ No
If YES, please provide more information about each hospitalization, to the best of your recollection:

Dates of Treatment ________ Institution ________ Reasons for hospitalization ____________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Have you ever received treatment for drug or alcohol problems (e.g., detox, rehab, outpatient therapy, Methadone treatment)?

□ Yes  □ No
If YES, list approximate date(s) and substance for which you received treatment

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
Your Medical History

Medical Problems

Please list all of your known medical conditions, *and when they were first diagnosed*:

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Surgery

*Please list any surgery you have had, and when each was done;*

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Medications

*Please list all medications you are currently taking, including nonprescription drugs. Include the frequency and dose, if known*

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Allergies

Drugs/Latex: .....................................................................................................................
Other: .................................................................................................................................
Your Family Medical Conditions

Please specify who in your family has the following diseases: consider grandparents, parents, aunts, uncles, siblings, children, nieces, nephews, grandchildren.

- Diabetes  □ Yes  □ No  If yes, then who? .....................
- Heart Disease  □ Yes  □ No  If yes, then who? .....................
- Stroke  □ Yes  □ No  If yes, then who? .....................
- Obesity  □ Yes  □ No  If yes, then who? .....................
- High Blood pressure  □ Yes  □ No  If yes, then who? .....................
- Thyroid problems  □ Yes  □ No  If yes, then who? .....................
- High cholesterol  □ Yes  □ No  If yes, then who? .....................
- Substance abuse disorders  □ Yes  □ No  If yes, then who? ...........
- Eating disorder (anorexia or bulimia) □ Yes  □ No  If yes, then who? ...........
- Other psychological disorder  □ Yes  □ No
  If yes, then who, and what type of disorder? ...........................................

- Cancers  □ Yes  □ No
  If yes, then who, and what type of cancer?.................................

Other diseases that run in your family? Please list which relatives have the problem

.................................................................

.................................................................

Your Medical Conditions

Pulmonary

□ Yes  □ No  Smoked within the past year
□ Yes  □ No  Require oxygen
□ Yes  □ No  Had a Pulmonary Embolism/blood clot in lung
□ Yes  □ No  Chronic obstructive pulmonary disease (COPD)
□ Yes  □ No  Obstructive sleep apnea
□ Yes  □ No  Use CPAP/BiPAP
□ Yes  □ No  Asthma
**Gastrointestinal**
- Yes □ No Heartburn requiring medications
- Yes □ No Gallstones or Had your gallbladder removed
- Yes □ No Pancreatitis
- Yes □ No Fatty liver disease
- Yes □ No Previous weight loss surgery

**Musculoskeletal**
- Yes □ No Back Pain
- Yes □ No Disc Disease in the Back
- Yes □ No Rheumatoid arthritis
- Yes □ No Osteoarthritis
- Yes □ No Musculoskeletal Disease
- Yes □ No limitation of activity by pain
- Yes □ No daily pain medication required
- Yes □ No surgery for joints planned
- Yes □ No mobility devices used (Cane, walker, etc)

**Renal/Kidney**
- Yes □ No Kidney disease (Creatinine > 2)
- Yes □ No Kidney Failure requiring dialysis
- Yes □ No Urinary or Stress Incontinence
- Yes □ No Kidney Stones

**Cardiac/Vascular**
- Yes □ No Heart attack
- Yes □ No Cardiac catheterization (stent in the heart)
- Yes □ No Cardiac surgery
- Yes □ No Elevated cholesterol
- Yes □ No High blood pressure
- Yes □ No Blood clot in the leg (DVT)
- Yes □ No Venous stasis
- Yes □ No Peripheral vascular disease
- Yes □ No Cellulitis
- Yes □ No Family History of Clots

**Endocrine**
- Yes □ No Diabetes Mellitus, Oral medications, or Insulin (Circle One)
- Yes □ No Insulin Resistance
- Yes □ No Diabetic eye disease
- Yes □ No Chronic Steroids/Immunosuppression
- Yes □ No Gout
- Yes □ No Thyroid disease
- Yes □ No Polycystic ovary disease
- Yes □ No Reproductive disorder
Neurologic
☐ Yes  ☐ No  Stroke
☐ Yes  ☐ No  Migraines
☐ Yes  ☐ No  Pseudotumor cerebri
☐ Yes  ☐ No  Headache
☐ Yes  ☐ No  Numbness

Other
☐ Yes  ☐ No  Blood thinner  Reason:__________
☐ Yes  ☐ No  Cancer  Type:_______________
☐ Yes  ☐ No  Rheumatologic Disorders