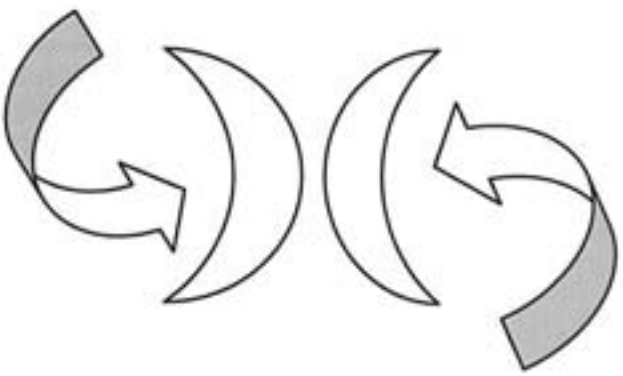
Weight and Lifestyle Inventory

(WALI)



The WALI is designed to assess your weight and dieting histories, your eating and exercise habits, and your relationships with family and friends. Your answers will help us better identify problem areas and develop an individualized treatment plan to help you achieve your goals. Please complete the questionnaire carefully and make a best guess when unsure of an answer. You may use the margins when you need more space for answers. You will have an opportunity to review your answers with our professional staff during your intake session. Please be assured that your information will be kept confidential.

Please allow 45-60 minutes to complete this questionnaire. Thank you for taking the time to do so. We look forward to helping your achieve your healthier lifestyle goals.

SECTION A: IDENTIFYING INFORMATION

_____

1 **Name** 2 **Today's Date**

_____ _____ _____lbs _____ft _____inches

3 **Date of Birth** 4 **Age** 5 **Weight** 6 **Height** 7 **BMI**

_____

8 **Address**

_____ _____ _____/____

9 **Phone: Day** 10 **Evening** 11 **Occupation/ # of yrs. at job**

12 **Highest year of school completed (circle one)**

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

High School College

13 **Ethnicity (circle all that apply):** American Indian Asian African American Hispanic White Other: _____

14 **How did you hear about our program?**

___Newspaper ___Physician ___Friend ___Other Professional

___Employer ___Website ___Other (Please specify_____)

SECTION B: WEIGHT HISTORY

1. **At what age were you first overweight by 10 lbs or more?**_____years old
   ****How do you remember that you were overweight at this time?** (e.g. pictures, clothes size, others telling you) _____

2. **What has been your highest weight after age 21?**_____lbs.,____yrs. old

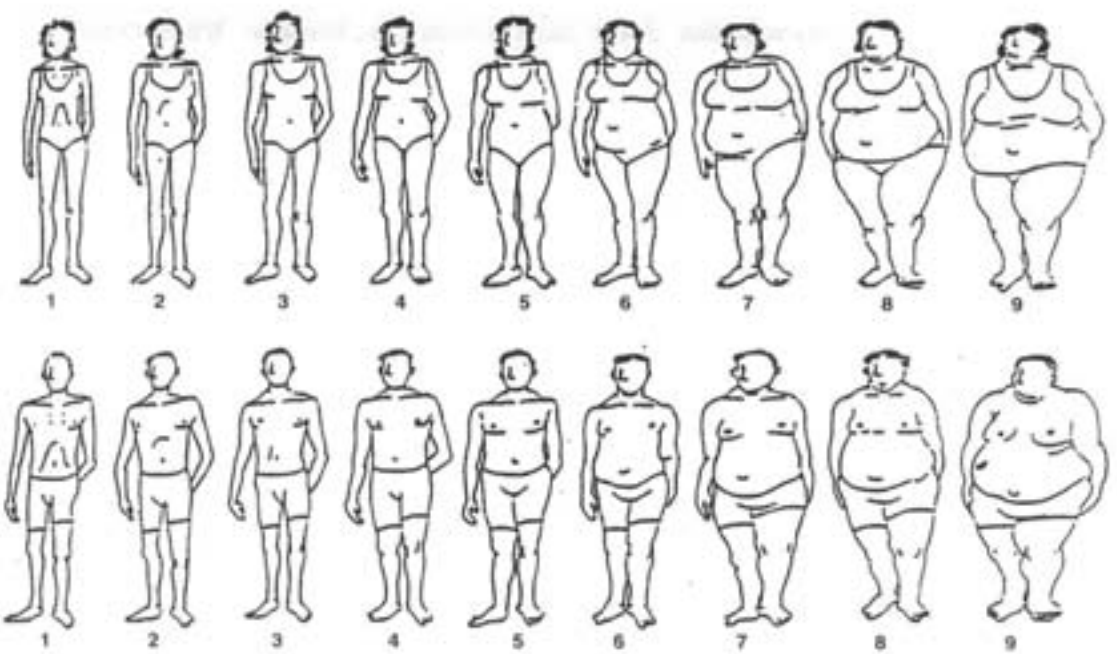
3. **What has been your lowest weight (not due to illness) after age 21, which you maintained for at least 1 year?**_____lbs. _____yrs. old, **maintained for** _____yrs.
   ****Was this weight reached after a weight loss effort?** (Circle one.) _____Yes _____No

4. **Circle the statement number below that best describes you. "During the past 6 months my weight has..."**

   1. decreased more than 10 lbs.
   2. decreased 5 to 10 lbs.
   3. been relatively stable.
   4. increased by 5 to 10 lbs.
   5. increased more than 10 lbs.

5. For each time period shown below, please list your maximum weight. If you cannot remember what your maximum 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, that most resembles your figure at that time. Record the number of the figure.

AGE	MAXIMUM WEIGHT	FIGURE #	FACTORS RELATED TO WEIGHT GAIN
a. 5-10	_____	_____	_____
b. 11-15	_____	_____	_____
c. 16-20	_____	_____	_____
d. 21-25	_____	_____	_____
e. 26-30	_____	_____	_____
f. 31-35	_____	_____	_____
g. 36-40	_____	_____	_____
h. 41-50	_____	_____	_____
i. 51-60	_____	_____	_____
j. 61-70	_____	_____	_____



SECTION C: FAMILY WEIGHT HISTORY

1. **Please indicate the average height and weight of your biological mother and father during their middle-age years and of your immediate family, including half-brothers and half-sisters. Please include a number for the figure on the previous page that is most similar to each individual's body shape. If you did not know either of these individuals', mark NA (not applicable) in the spaces.**

Parent	Height (ft&in)	Weight (lbs)	Current Age or year of death	Figure#
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Spouse/Sign. Other	_____	_____	_____	_____

List siblings by gender and order, and provide the above information for each:

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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

1. **Have you borne children?** (Circle 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 first 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 first 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?** (Circle one.) Yes No
   If yes,

   A. **Describe your eating around the time of your menstruation.** (Circle one.)
   Eat much less Eat less No Change Eat More Eat Much More

   B. **Do you crave particular foods around the time of your menstruation?** (Circle one.) Yes No
   ****If yes, which foods do you crave?** _____

SECTION E: WEIGHT LOSS HISTORY

1. **Please record any major weight loss efforts (i.e., diet, exercise, moderation, etc.) that resulted in a weight loss of 10 pounds or more. Think about 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 until you reach your most recent one.**

	Age at time of effort	Weight at start of effort	#lbs lost	Method used to lose weight
a.	_____	_____	_____	_____
b.	_____	_____	_____	_____
c.	_____	_____	_____	_____
d.	_____	_____	_____	_____
e.	_____	_____	_____	_____
f.	_____	_____	_____	_____

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

2. **<u>In the past year</u>, how many times have your started a weight loss program on your own that lasted for more than 3 days?**_____

3. **<u>In the past year</u>, how many times have your started a weight loss program on your own that lasted for 3 days or less?**_____

4. **Have you ever experienced any significant physical or emotional symptoms while attempting to lose weight or after losing weight?** (Circle one.) Yes No

If you answered "yes" to question 4, please describe your symptoms, including when they began, how long they lasted, and the type of help you sought, if any.

_____
_____
_____
_____

SECTION F: WEIGHT LOSS GOALS

1. **How much would you like to weight at this time?**_____ lbs.

2. **When did you last weigh this amount?** _____(month, year, & age)

3. **How long was this weight maintained?** _____ months

6. **If you are successful in our program in changing your eating and exercising habits, how much weight do you realistically <u>expect</u> to lose after:**
   a. 1 month _____ lbs. b. 3 months _____ lbs. c. 6 months _____ lbs. d. 12 months _____ lbs.

SECTION G: SUBSTANCE USE

1. **Do you smoke cigarettes?** (Circle one.) Yes No

2. **Have you ever smoked cigarettes and stopped?** (Circle one.) Yes No
   If Yes to 1 and/or 2,
   a. **How many cigarettes do/did you smoke in a day?** _____/day
   b. **How many years have you/did you smoke(d)?** _____years
   c. **If you quit, when did you stop?** _____
   d. **If you quit smoking, did you experience weight gain after quitting?** (Circle one.) Yes No
      ****If Yes, how many pounds?**_____

3. **During the past year,**
   a. **How many days/times per week do you consume alcohol?** _____
   b. **How much (and what type of alcohol) do you drink in 1 week, on average?** _____
      _____

4. **What other substances do you or have you used in the past?** _____

5. **Have you ever had a problem with (or received treatment for) alcohol consumption or the use of other drugs?** (Circle one.) Yes No
   If yes, please explain:_____
   _____
   _____
   _____

SECTION H: EATING HABITS

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

   1. does not contribute at all
   2. contributes a small amount
   3. contributes a moderate amount
   4. contributes a large amount
   5. contributes the greatest amount

____ A. Eating too much food
____ B. Overeating at breakfast
____ C. Overeating at lunch
____ D. Overeating at dinner
____ E. Snacking between meals
____ F. Snacking after dinner
____ G. Eating because I feel physically hungry
____ H. Eating because I crave certain foods
____ I. Continuing to eat because I don't feel full after a meal
____ J. Eating because I can't stop once I've begun
____ K. Eating because of the good taste of foods
____ L. Eating in response to sight or smell of food
____ M. Eating while cooking or preparing food
____ N. Eating when anxious
____ O. Eating when tired
____ P. Eating when bored
____ Q. Eating when stressed
____ R. Eating when angry
____ S. Eating when depressed/upset
____ T. Eating when socializing/celebrating
____ U. Eating when happy
____ V. Eating when alone
____ W. Eating with family/friends
____ X. Eating at business functions

Please indicate any other factors that contribute a moderate or amount to your weight gain.

_____

_____

_____

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. **Who does the food shopping?**_____

5. **Do you have any food allergies?** (Circle one.) Yes No
   If yes, please specify the food and the allergic reactions.

_____

_____

6. **Please specify the amounts (in cups, 8 oz.) of the following fluids you typically consume in one day.**

   _____skim milk _____low-fat milk _____whole milk _____seltzer water

   _____water _____fruit juice _____tea _____coffee _____diet soda

   _____regular soda _____beer _____wine _____hard liquor _____other

7. **During a typical week, how many meals do you eat at a fast food restaurant (including drive thru and convenience stores) and how many meals do you eat at a traditional restaurant, coffee shop, cafeteria, or similar establishment?**

Fast Food Restaurants		**Traditional Restaurants**	
Breakfast	_____meals a week	Breakfast	_____meals a week
Lunch	_____meals a week	Lunch	_____meals a week
Dinner	_____meals a week	Dinner	_____meals a week

8. **Where do you usually eat out? (Please list the top 3 restaurants/establishments)**

_____

_____

SECTION I: INTAKE RECALL

Please indicate the foods you consume on a typical weekday.

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

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

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

SECTION J: EATING PATTERNS I

The following questions on eating patterns are adapted from the Questionnaire on Eating and Weight Patterns – Revised by Yanovski, S.Z. (1993). Obesity Research, 1, 306-324.

1. **During the past 6 months, how often, on average, if at all, did you eat unusually large amounts of food?** (There may have been some weeks when it was not present - just average those in.) (Circle one)

   a. Less than one day a week
   b. One day a week
   c. Two or three days a week
   d. Four or five days a week
   e. Nearly every day
   f. None, I do not eat large amounts at one time

IF "F": SKIP TO QUESTION 8 in this section. Do not complete questions 2-7.

2. **If there were times when you ate unusually large amounts of food, did you feel you could not stop eating or control what or how much you were eating at those times?** (Circle one) Yes No

3. **Did you usually have any of the following experiences during these occasions**? Complete all times.

   a. Eating much more rapidly than usual? (Circle one) Yes No

   b. Eating until you felt uncomfortably full? (Circle one) Yes No

   c. Eating large amounts of food when you didn't feel physically hungry? (Circle one) Yes No

   d. Eating alone because you were embarrassed by how much you were eating? Yes No

   e. Feeling disgusted with yourself, depressed, or feeling very guilty after overeating? Yes No

   f. Eating within 2.5 hours of having eaten another meal? Yes No

4. **Think about a typical time when you ate this way** (that is, large amounts of food and feeling that your eating was out of control).
   ****What time of day did the episode start? _____**

5. **Approximately how long did this episode of eating last, from the time you started to eat until when you stopped and did not eat again for at least two hours?** _____hours _____minutes

6. **As best as you can remember, please list everything you may have eaten or drunk during that episode. Estimate as best as you can.** _____
_____
_____

7. **In general, during the past 6 months, how upset were you by overeating episodes**? (Circle one)
   a. Not at all
   b. Slightly
   c. Moderately
   d. Greatly
   e. Extremely

8. **During the past 6 months, how often, if at all, have you made yourself vomit?** (Circle one)
   a. I have NOT
   b. Less than once a week
   c. Once a week
   d. 2-3 times a week
   e. 4-5 times a week
   f. More than 5 times a week

9. **During the past 6 months, how often, if at all, did you take more than twice the recommended dose of laxatives**? (Circle one)
   a. I have NOT
   b. Less than once a week
   c. Once a week
   d. 2-3 times a week
   e. 4-5 times a week
   f. More than 5 times a week

10. **During the past 6 months, how often, if at all, did you take more than twice the recommended dose of diuretic (water pills)**? (Circle one)
   a. I have NOT
   b. Less than once a week
   c. Once a week
   d. 2-3 times a week
   e. 4-5 times a week
   f. More than 5 times a week

11. **During the past 6 months, how often, if at all, did you fast (not eat anything at all for at least 24 hours)?** (Circle one)
   a. I have NOT
   b. Less than once a week
   c. Once a week
   d. 2-3 times a week
   e. 4-5 times a week
   f. More than 5 times a week

12. **During the past 6 months, how often, if at all, did you exercise for more than one hour specifically in order to avoid gaining weight after eating**? (Circle one)
   a. I have NOT
   b. Less than once a week
   c. Once a week
   d. 2-3 times a week
   e. 4-5 times a week
   f. More than 5 times a week

13. **During the past 6 months, how often, if at all, did you take more than twice the recommended dosage of a diet pill**? (Circle one)
   a. I have NOT
   b. Less than once a week
   c. Once a week
   d. 2-3 times a week
   e. 4-5 times a week
   f. More than 5 times a week

SECTION K: EATING PATTERNS II

Please circle ONE answer for each question below.

1. **How hungry are you usually in the morning?**

0	1	2	3	4
Not at all	A little	Somewhat	Moderately	Very

2. **Do you have cravings or urges to eat snacks after supper, but before bedtime?**

0	1	2	3	4
Not at all	A little	Somewhat	Very much so	Extremely so

3. **Are you currently feeling blue or down in the dumps?**

0	1	2	3	4
Not at all	A little	Somewhat	Very much so	Extremely

4. **When you are feeling blue, is your mood lower in the:**

0	1	2	3	4
Early Morning	Late Morning	Afternoon	Early Evening	Late Evening/ Nighttime

5. **How often do you have trouble getting to sleep?**

0	1	2	3	4
Never	Sometimes	About half the time	Usually	Always

***********If 0 on #5, Please Skip to Section L: Physical Activity*******************

6. **Do you have cravings or urges to eat snacks when you wake up at night?**

0	1	2	3	4
Not at all	A little	Somewhat	Very much so	Extremely so

7. **When you get up in the middle of the night, how often do you snack?**

0	1	2	3	4
Not at all	Sometimes	About half the time	Usually	Always

8. **How long have your difficulties with night eating been going on?** _____months _____years

SECTION L: PHYSICAL ACTIVITY

1. **Do you have any physical problems that limit your physical activity**? (Circle one.) Yes No
   If yes, please describe. _____
   _____

2. **Please rank your enjoyment in the following types of physical activity? (1 = most preferred)**

   a.____walking outside b.____biking outside c.____jogging d.____aerobic class

   e.____tennis/racket sports f.____running g.____swimming h.____basketball

   i.____strength training j.____walking (indoors, including treadmill) k.____dancing

   m.____golf n.____other, please describe _____

3. **For your most preferred activity, how many times per week and for how long have you engaged in this activity in the past 6 months?** _____times/week _____ months

4. **How many hours of TV do you watch on an average weekday**? ___hrs

5. **How many hours of TV do you watch on an average weekend day**? ____hrs

6. **Approximately how many city blocks do you walk each day**? (12 blocks=1 mile) _____blocks

7. **How many flights of stairs do you climb up each day? ____/day** (1 flight = 10 steps)

8. **How active are you?** Pick a number from 1 to 10 (1 = very sedentary, 10 = very active). _____

SECTION M: FAMILY AND LIVING ARRANGEMENTS

1. **I am currently:** (check one)
   _____ Single _____ Married _____ Divorced _____ Separated _____ Widowed

2. **Currently, I live with**: (check ALL that apply)
   _____ No one _____ spouse _____ significant other _____ children
   _____ parents/step-parents _____ other relatives _____ roommates

3. **Please indicate the total numbers of persons living in your home.**_____

If you are currently involved in an intimate relationship, please answer Questions 4-6.

4. **What is this person's attitude toward your efforts to lose weight.** (Circle one).
   ___ Strongly Supports ___ Supports ___ Neutral ___ Opposes ___ Strongly Opposes
   ****Please describe briefly what this person does to help or hinder your weight loss efforts.**
   _____

5. **How satisfied are you with your overall relationship with this person**? (Circle one)
   ___ Very Satisfied ___ Satisfied ___ Neutral ___ Dissatisfied ___ Very Dissatisfied

6. **Who do you anticipate will support your weight loss efforts?**_____
   Will anyone oppose or undermine your weight loss efforts? (Circle one) Yes No
   If yes, how many will? _____ Who are these people? _____

SECTION N: SELF-PERCEPTIONS

1. **In general, <u>during the past 6 months</u>, how important has your weight or shape been in how you feel about or evaluate yourself as a person compared to other aspects of your life (i.e. how you do at work, as a parent, or how you get along with other people?)**
   Weight and shape…
   a. Were not very important.
   b. Played a part in how I felt about myself.
   c. Were among the main things that affected how I felt about myself
   d. Were the most important things that affected how I felt about myself

For questions 2-4, please circle the response that corresponds with the following scale.

0	**1**	**2**	**3**	**4**
Strongly Disagree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**

2. **"I am satisfied with my current weight and shape (figure or physique)."**
   0 1 2 3 4

3. **"I am satisfied with my current overall appearance."**
   0 1 2 3 4

4. **"In general, I am happy with who I am."**
   0 1 2 3 4

5. **"As compared with most people, I think I have good self-esteem."**
   0 1 2 3 4

SECTION O: PSYCHOLOGICAL FACTORS:

1. **Have you ever had any problems, at anytime, with depression, anxiety or other emotions that disrupted your normal functioning?** (Circle one) Yes No

   If yes, please describe the nature and duration of these problems, including any professional help you sought for treatment of these emotional problems.

   _____
   _____
   _____
   _____
   _____
   _____

3. During the past month, have you felt depressed, sad, or blue much of the time? (Circle one) Yes No

4. During the past month, have you often felt hopeless about the future? (Circle one) Yes No

5. During the past month, have you had little interest or pleasure in doing things? (Circle one) Yes No

SECTION P: TIMING

1. **Please explain if you are currently experiencing any greater than usual stress in your life in any of the following categories: work, health, relationship with spouse/significant other, children, parents, legal/financial trouble, school, moving, other.**

   _____
   _____
   _____
   _____
   _____
   _____

2. **Please explain if you are planning any major life changes (i.e. new job, moving, relationship, etc.) during the next 6 months?**

   _____
   _____
   _____

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

   _____
   _____
   _____

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

   _____
   _____

8. **People who want to achieve long-term weight control need to spend at least 30 minutes a day, for a minimum of 6 months trying to change their eating, exercise, and thinking habits.**

   Please check the number below which best describes you:

   _____1. I definitely will not be able to devote 30 minutes daily to weight control.
   _____2. I'm not sure if I can find 30 minutes daily for weight control.
   _____3. I can definitely find 30 minutes daily for weight control.
   _____4. I can devote more than 30 minutes daily to weight control.

9. **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 all confident and 10 = extremely confident.** Your number is _____.

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

_____
_____
_____
_____
_____
_____
_____

SECTION Q: MEDICAL HISTORY

1. Please place a checkmark in the column by any of the following conditions that apply to you.

Condition	√	Condition	√
Heart disease		**Gallbladder disease**	
Angina (chest pains)		**Thyroid disease**	
Palpitations, heart beats fast or hard		**Kidney disease**	
Stroke, mild stroke (cerebrovascular accident)		**Ulcers**	
Sleep Apnea		**Bowel disease**	
Breathing Problems (Asthma, lung disease)		**Liver disease**	
High blood pressure		**Joint or bone problems**	
Anemia		**Diabetes (type I or II)** ***(If, yes, see next page)***	
Back Problems		**Rheumatic Fever**	
Hiatal hernia		**Heart Murmur**	
Arthritis		**Pacemaker**	
Gout (elevated uric acid)		**Other (specify)**	

SECTION R: DIABETES HISTORY

(Only for people with diabetes)

Please answer the following questions about your diabetes management.

1. **How long have you had diabetes?** _____
2. **What type of treatment are you on?** _____
3. **How often do you monitor your blood glucose?** _____
   a. **What meter do you use?** _____
4. **What do you want your blood sugar to be?** _____
5. **How often do you experience low blood sugar?** __Daily __Weekly __Monthly __ Never
   What symptoms did you get?_____
   What did you do to correct it? _____
6. **How often do you get the symptoms of high blood sugar?** (fatigue, frequent urination, thirst) **Daily**_____ **Weekly**_____ **Monthly**_____
7. **Have you been hospitalized for diabetes in the past year?** (Circle one) Yes No
   If yes, for what reason? _____
8. **Have you ever attended a diabetes education program?** (Circle one) Yes No
9. **What is the most difficult part of taking care of your diabetes?** _____

SECTION S: Medication Management

Please list all medications you currently take (including vitamins and supplements). Please indicate the dosage and frequency (number of times a day) of each medication.

Medication	Dosage	Frequency	Reasons for taking