Center for Weight & Wellness
The Miriam Hospital
Lifespan. Delivering health with care.®

1377 South County Trail, Unit 1A
East Greenwich, Rhode Island 02818
146 West River Street, Suite 11A
Providence, Rhode Island, 02904
Phone: 401-793-8790 FAX: 401-793-8709
Medical Director: Vincent Pera, MD

CENTER FOR WEIGHT AND WELLNESS QUESTIONNAIRE

VERY IMPORTANT: *Please bring this completed packet with you to your orientation seminar. Thank you!*

Today's Date: _____

Name : _____ **DOB:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Telephone #: Home: _____ **Work:** _____ **Cell:** _____

Email address: _____ *(if OK to contact you via email)*

Sex: ☐ M ☐ F **Height:** _____ **Weight:** _____ **Social Security #:** _____

Preferred Language: _____ **Written:** _____ **Spoken:** _____

Ethnicity: Are you Hispanic or Latino? ☐ No ☐ Yes

Race: ☐ Caucasian ☐ Black/African American ☐ Asian/Pacific Islander ☐ Don't Know/Refuse

☐ Other (describe) _____

How did you hear about the Center for Weight and Wellness? *Please check one:*

☐ Friend or relative ☐ Physician or other health care provider ☐ Internet ☐ *Weigh to Health* Newsletter

☐ Newspaper ☐ Television Ad ☐ Radio ☐ Other, *please specify*: _____

Please continue on next page.

PERSONAL HISTORY

Where were you born? (city and state) _____

Where were you raised? (list all cities and states) _____

Who raised you? Check ALL that apply: ☐ Mother ☐ Father ☐ Grandmother

☐ Grandfather ☐ Other relative ☐ Step-mother ☐ Step-father ☐ Other: _____

Do you have siblings? List the number of each: ____Brothers ____Sisters ____Step-brothers

____ Step-sisters ____Half-brothers ____Half-sisters ____Adoptive brothers ____Adoptive sister

MARITAL STATUS

☐ Single ☐ Married ☐ Living w/Significant Other ☐ Separated ☐ Divorced ☐ Widowed

Dates of your marriages/cohabitations: _____ ☐ Not applicable

Dates for your divorces/separations: _____ ☐ Not applicable

Number of biological/adopted children that you have: _____ Their ages: _____

Number of step-children that you have: _____ Their ages: _____

CURRENT LIVING ARRANGEMENTS

Where do you live? Check all that apply.

☐ Rented apartment/home ☐ Own home ☐ With friend/family member

Who lives with you? Check all that apply.

☐ Spouse/partner ☐ Child (ren) ☐ Parent(s) ☐ In-law(s) ☐ Other : _____

ACADEMIC HISTORY

What is your highest level of education?

☐ Grade___ ☐ High School ☐ GED ☐ Technical School ☐ Some College

☐ Associate Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ PhD/MD/JD

Did you have any learning difficulties?

☐ No ☐ Yes *If yes, problems with* ☐ Reading ☐ Writing ☐ Math ☐ Sustaining Attention

Did you participate in special education classes? ☐ No ☐ Yes

EMPLOYMENT STATUS

What is your work status?

☐ Work Full-time ☐ Work Part-time ☐ Homemaker ☐ Retired ☐ Volunteer
☐ Unemployed ☐ Temporary Disability ☐ Permanent Disability ☐ Student

Work Shift: ☐ Days ☐ Nights ☐ Rotating shifts ☐ Other: _____ ☐ N/A

If you work outside of the home, what is your job title? _____

If unemployed or disabled, are you collecting benefits? ☐ No ☐ Yes, list benefit: _____

Are you now experiencing significant financial strain? ☐ No ☐ Yes, due to: _____

Does your spouse/partner?

☐ Work Full-time ☐ Work Part-time ☐ Homemaker ☐ Retired ☐ Volunteer
☐ Unemployed ☐ Temporary Disability ☐ Permanent Disability ☐ Student

If your spouse/partner works outside of the home, what is his/her job title?_____

HOUSEHOLD INCOME STATUS FROM ALL SOURCES

☐ $0-9,999 ☐ $10,000-19,000 ☐ $20,000-29,999 ☐ $30,000-39,999 ☐ $40,000-49,999
☐ $50,000-59,999 ☐ $60,000-69,999 ☐ $70,000-79,999 ☐ $80,000-89,999 ☐ $90,000+

PRIMARY CARE PHYSICIAN (PCP)

PCP Name:

_____/_____/_____

First Name **Middle Initial** **Last Name**

Address:_____

Telephone:_____

Date last seen by your PCP: _____ ☐ I do not have a Primary Care Physician

MEDICAL HISTORY

REVIEW OF SYSTEMS: Please indicate any that apply to you.

Constitutional Symptoms	YES	NO	Cardiovascular	YES	NO
Change in appetite			Chest pain		
Fatigue			Leg swelling		
Weight gain/loss			Palpitations		
Other:			Shortness of breath with activity		
			Shortness of breath at rest		
Head and Neck	**YES**	**NO**	Other:		
Dental problem					
Ear or hearing problem			**Gastrointestinal**	**YES**	**NO**
Mouth sores			Abdominal pain		
Trouble swallowing			Rectal bleeding		
Other:			Blood in stool		
			Constipation		
Eyes	**YES**	**NO**	Diarrhea		
Visual disturbance or vision changes			Nausea		
Other:			Vomiting		
			Heartburn		
Respiratory	**YES**	**NO**	Other:		
Sleep Apnea					
Chest Tightness			**Endocrine**	**YES**	**NO**
Cough			Heat intolerance		
Shortness of Breath			Cold intolerance		
Wheezing			Excessive thirst		
Blood in sputum			Excessive hunger/appetite		
Snoring			Excessive urination		
Fall asleep during the day			Other:		
Other:					

REVIEW OF SYSTEMS (Continued)					
Genitourinary - Women	**YES**	**NO**	**Skin**	**YES**	**NO**
Pain or difficulty with urination			Rash		
Incontinence			Other:		
Flank pain					
Frequent urination			**Allergies/ Immune System**	**YES**	**NO**
Blood in urine			Environmental allergies		
Ovarian cysts			Food allergies		
Other:			Immunocompromised		
Genitourinary - Men	**YES**	**NO**	**Nervous System**	**YES**	**NO**
Pain or difficulty with urination			Dizziness		
Incontinence			Frequent Headaches		
Flank pain			Light-headedness		
Frequent urination			Numbness		
Blood in urine			Seizures		
Enlarged prostate			Fainting		
Other:			Weakness		
Musculoskeletal	**YES**	**NO**	**Breast Health**	**YES**	**NO**
Joint pain			Breast lumps		
Chronic back pain			Breast skin changes		
Joint swelling			Nipple discharge		
Muscle pain			Breast tenderness		
Neck pain					
Gout					
Chronic knee pain					
Chronic neck pain					
Chronic hip pain					

Check all medical conditions that YOU have now (current) or that you have ever had (past). For any past medical conditions, please also include the date(s) that you experienced the condition.

Current	Past *Include DATE(S)	Medical Condition
Ex: ✓	***since 2014***	***Diabetes***
Ex:	***2/2002***	***Stroke***
		Anemia
		Arthritis
		Asthma
		Bleeding disorder
		Blood clot / DVT (Deep Vein Thrombosis)
		Heart attack
		Heart arrhythmias or atrial fibrillation
		Heart valve problems
		Other heart, circulation, or vascular problems (aneurysms, coronary artery disease, peripheral artery disease)
		Cancer - List type(s):
		Diabetes
		Gallstones or Cholecystectomy
		Gastritis
		Gastroesphogeal Reflux Disorder (GERD)
		Gout
		Hiatal hernia
		High blood pressure
		High cholesterol
		Irritable Bowel Syndrome
		Jaundice
		Kidney disease
		Kidney stones
		History of Pneumonia
		Polycystic Ovary Syndrome
		Pulmonary Disease (COPD)
		Sleep Apnea
		Stroke
		Thyroid problems
		Ulcer
		Other:

List all hospitalizations, surgeries, or other medical procedures that you had and their dates:

	Yes/No
Do you take Aspirin or Plavix?	
Do you take ibuprofen or other anti-inflammatory medication frequently?	
Do you take any blood thinning medications?	
Have you taken steroids in the past year?	

Please continue on next page.

FAMILY MEDICAL HISTORY

Check all that apply. Please indicate which family member had any of the listed medical conditions by checking the appropriate box.

	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Obesity								
Diabetes								
High Blood Pressure								
Cancer								
Heart Disease								
Stroke								
Arthritis								
High Cholesterol								
Other								

ALLERGIES

Check off any allergies that you have:

☐ None known ☐ Environmental/Seasonal ☐ Animal Dander ☐ Latex

☐ Food: _____ ☐ Medication: _____ ☐ Other: _____

Please continue on next page.

MEDICATIONS

Please list all *prescription* medication that you take, and circle the appropriate dosage and times taken:

Medication Name	Dosage	Times taken	Reason taking medication
Example: Norvasc	*5* Mg, mcg, pills, units	*1* Per day, week, month	*High blood pressure*
Example: Ativan	*2* Mg, mcg, pills, units	*3* Per day, week, month *As needed*	*Anxiety*
	Mg, mcg, pills, units	Per day, week, month	
	Mg, mcg, pills, units	Per day, week, month	
	Mg, mcg, pills, units	Per day, week, month	
	Mg, mcg, pills, units	Per day, week, month	
	Mg, mcg, pills, units	Per day, week, month	
	Mg, mcg, pills, units	Per day, week, month	
	Mg, mcg, pills, units	Per day, week, month	
	Mg, mcg, pills, units	Per day, week, month	
	Mg, mcg, pills, units	Per day, week, month	
	Mg, mcg, pills, units	Per day, week, month	
	Mg, mcg, pills, units	Per day, week, month	
	Mg, mcg, pills, units	Per day, week, month	

Please list any *over-the-counter medication*, *vitamin supplements*, or *herbal remedies* that you take:

Name	Dosage	Times taken	Reason taking medication
Example: Vit D3	*2000* Mg, mcg, pills, units	*1* Per day, week, month	*Vitamin deficiency*
Example: ibuprofen	*400* Mg, mcg, pills, units	*Up to 4* Per day, week, month *As needed*	*Headaches*
	Mg, mcg, pills, units	Per day, week, month	
	Mg, mcg, pills, units	Per day, week, month	
	Mg, mcg, pills, units	Per day, week, month	
	Mg, mcg, pills, units	Per day, week, month	
	Mg, mcg, pills, units	Per day, week, month	
	Mg, mcg, pills, units	Per day, week, month	
	Mg, mcg, pills, units	Per day, week, month	

MENTAL HEALTH HISTORY

Have you ever been evaluated for emotional problems? ☐ No ☐ Yes

If yes, what was the diagnosis?

_____

Have you ever had a psychiatrist or another doctor prescribe medication for a mental health problem? ☐ No ☐ Yes **If yes, what was the medication?**

☐ Antidepressant (e.g., Celexa, Lexapro, Wellbutrin) _____

☐ Mood Stabilizer (e.g., Lithium, Lamictal) _____

☐ Anxiety Medication (e.g., lorazepam, clonazepam) _____

☐ ADHD Medication (e.g., Adderall, Concerta) _____

☐ Antipsychotic Medication (e.g., Abilify, Seroquel) _____

Have you ever received counseling (individual, couples, family) from a mental health professional?
☐ No ☐ Yes If yes, when and for what?

_____

_____

Have you ever been hospitalized for a mental health problem (partial hospital program, inpatient)?
☐ No ☐ Yes If yes, when and for what?

_____

_____

Have you received other types of treatment for mental health problems?
☐ No ☐ Yes If so, what: ☐ ECT ☐ Biofeedback ☐ Other: _____

SOCIAL SUPPORT

Who do you turn to when you need to talk about a problem or get help with something?

☐ Spouse/partner ☐ Child(ren) ☐ Parent(s) ☐ In-law(s) ☐ Friend(s)
☐ Co-worker ☐ Clergy ☐ No one ☐ Other: _____

Please continue on next page.

HEALTH MAINTENANCE BEHAVIORS

Have you ever smoked cigarettes or used other tobacco products?

☐ Never

☐ Former—Quit Date: _____ # of packs each day used to smoke: _____ For how many years?: ___

Have you smoked at least 100 cigarettes in your entire life (5 packs =100 cigarettes)? ☐ No ☐ Yes

☐ Current Smoker # of packs each day _____ How many years? _____

Interested in quitting ☐ No ☐ Yes

During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking? ☐ No ☐ Yes

Have you smoked at least 100 cigarettes in your entire life (5 packs =100 cigarettes)? ☐ No ☐ Yes

☐ Use other tobacco products (e.g., cigars, chewing tobacco) ☐ No ☐ Yes

How much sleep do you get each night? _____hours

Do you feel rested after sleep? ☐ No ☐ Yes

Check off any problems that you have with sleep. ☐ None ☐ Problems falling asleep

☐ Problems staying asleep ☐ Restless legs ☐ Loud snoring ☐ Excessive sleepiness during the day

☐ Sleep apnea—if yes, do you regularly use CPAP ☐ No ☐ Yes

Do you nap during the day? ☐ No ☐ Yes; how many times per week? _____ for how long? ___mins

How many meals per day do you eat? _____

What do you typically eat for breakfast? _____

What do you typically eat for lunch? _____

What do you typically eat for dinner? _____

What foods do you snack on? _____

Do you drink any beverages with caffeine?

Coffee ☐ No ☐ Yes; Number of 8 oz. cups per day: _____

Tea (black, green, or white unless labeled decaffeinated) ☐ No ☐ Yes; Number of 8 oz. cups/day: ____

Soda (e.g.,Colas, Dr. Pepper, Mountain Dew—diet or regular) ☐ No ☐ Yes; Number of 8 oz. cups/day: ____

Energy drinks ☐ No ☐ Yes, Number of cans per day: _____

Use of Recreational Drugs and Alcohol

Do you use recreational drugs?

☐ No ☐ Yes **If yes, how many times** _____ per ***day*** or _____ per ***week*** or _____ per ***month***

If so, what drugs do you use?

☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Amphetamines

☐ Barbiturates ☐ Pain Medications ☐ Other: _____

Has anyone ever told you to cut back on your use of recreational drugs? ☐ No ☐ Yes

Did you ever seek treatment for a substance abuse problem (e.g., Narcotics Anonymous, Rehabilitation)

☐ No ☐ Yes

Please describe and give dates of treatment: _____

Did you ever seek treatment for a drinking problem (e.g., AA, rehabilitation) ☐ No ☐ Yes

Please describe and give dates of treatment: _____

Please continue on next page.

This is one unit of alcohol…

…and each of these is more than one unit

1. **How often did you have a drink containing alcohol in the past year?**

___ a. Never
___ b. Monthly or less
___ c. Two to four times a month
___ d. Two to three times per week
___ e. Four or more times a week

2. **How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?**

___ a. 0 drinks
___ b. 1 or 2
___ c. 3 or 4
___ d. 5 or 6
___ e. 7 to 9
___ f. 10 or more

3. **How often did you have six or more drinks on one occasion in the past year?**

___ a. Never
___ b. Less than monthly
___ c. Monthly
___ d. Weekly
___ e. Daily or almost daily

Please continue on next page.

MEDICAL CARE CONCERNS

Have you had ***problems***:

- Finding understanding doctors? ☐ No ☐ Yes
- Keeping medical appointments (e.g., transportation, child care)? ☐ No ☐ Yes
- Taking medications as prescribed (e.g., due to cost, side effects, forgetting to take them, change to generic, complicated directions, taking more than prescribed)? ☐ No ☐ Yes
- Taking someone else's prescription medications? ☐ No ☐ Yes

WEIGHT MANAGEMENT HISTORY

What was your **lowest** weight as an adult (18 years or over) _____ lbs.

What was your **highest** weight as an adult (18 years+; for women, not when pregnant) _____ lbs.

What is the **most** weight that you have lost? _____ lbs.

How old were you when you began to have a weight problem? _____ years

The following set of questions asks you to consider your dream weight, your happy weight, your acceptable weight, and your disappointed weight. Please provide a number (in lbs.) that corresponds to each:

Your ***dream weight*** – a weight you would choose if you could weight whatever you wanted.

Dream weight: _____ pounds

Your ***happy weight*** – not as ideal as the first one above, however one that you would be happy to achieve.

Happy weight: _____ pounds

Your ***acceptable weight*** – one that you would not be particularly happy with, but one you could accept since it would be less than your current weight.

Acceptable weight: _____ pounds

Your ***disappointed weight*** – one that is less than your current weight, but one that you could not view as successful in any way. You would be disappointed if this was your final weight after the program.

Disappointed weight _____ pounds

Please continue on next page.

Methods of Weight Loss Tried in the Past

Type	When and how many times?	How long did you participate in or use this method?	How many pounds did you lose?	How long did you maintain your weight loss?
Bariatric Surgery				
The Miriam Hospital Weight Management Program				
Weight Watchers				
Jenny Craig				
NutriSystem				
Medifast				
Medi Weight Loss				
Weight Loss Research Study				
Lowered food intake on my own				
Increased exercise on my own				
Orlistat				
Phentermine				
Fenfluramine				
Meridia				
Xenical				
Qsymia				
Belviq				
Saxenda				
Alli				
Metabolife				
Herbalife				
Dexatrim				
Slimfast				
Hydroxycut				
Personal Trainer				
Nutritionist for Weight Management only				
Overeaters Anonymous				
Take Off Pounds Sensibly				
Other:				
Other:				

The following questions ask for your views about your health, how you feel and how well you are able to do your usual activities. If you are unsure about how to answer any questions, please give the best answer you can. Do not spend too much time in answering as your immediate response is likely to be the most accurate. These questions are about how you feel and how things have been with you during the past month. How much time during the last month:

	All of the time	**Most of the time**	**A good bit of the time**	**Some of the time**	**A little of the time**	**None of the time**
a. Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
b. Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
c. Have you felt downhearted and low?	☐	☐	☐	☐	☐	☐
d. Has your health limited your social activities?	☐	☐	☐	☐	☐	☐

1. **In general, would you say your health is**:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. **How much does your health limit your activities?**

	Yes, limited a lot	**Yes, limited a little**	**No, not at all limited**
a. Moderate activities such as moving a table	☐	☐	☐
b. Climbing several flights of stairs	☐	☐	☐

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

	Yes	**No**
a. Accomplished less than you would like	☐	☐
b. Were limited in the kind of work or other activities	☐	☐

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

	Yes	**No**
a. Accomplished less than you would like	☐	☐
b. Didn't do work or other activities as carefully as usual	☐	☐

5. **During the past 4 weeks, how much did pain interfere with your normal work?**

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Using the scale below, please describe your work experience in the past month. Please fill out this questionnaire if you are employed. Indicate below your response:

Are you employed ☐ No ☐ Yes

If applicable last date of employment: _____

These experiences may be affected by many environmental; factors, and may change from time to time. For each of the following statements, please **circle** the number that best shows your agreement or disagreement with the statement in describing your **work experience** in the **past month**.

	Strongly Disagree	Somewhat Disagree	Uncertain about your agreement	Somewhat Agree	Strongly Agree
Because of my weight problem, the stresses of my job were much harder to handle.	1	2	3	4	5
Despite having my weight problem, I was able to finish hard tasks in my work	1	2	3	4	5
My weight problem distracted me from taking pleasure in my work	1	2	3	4	5
I felt hopeless finishing certain work tasks due to my weight problem.	1	2	3	4	5
At work, I was able to focus on achieving my goals despite my weight problem.	1	2	3	4	5
Despite my weight problem, I felt energetic enough to complete all my work.	1	2	3	4	5

Please continue on next page.

1. During a typical **7-Day period** (a week), how many times on average do you do the following kinds of exercise for **more than 15 minutes** during your free time (leisure time).

Entering "0" if no exercise, or "1-7" for times per week for exercise, (Write on each line the appropriate number).

	Times Per Week
a) STRENUOUS EXERCISE (HEART BEATS RAPIDLY) (e.g., running, jogging, hockey, football, soccer, squash, basketball, cross country skiing, judo, roller skating, vigorous swimming, vigorous long distance bicycling)	_____ **Enter 0 if no exercise**
b) MODERATE EXERCISE (NOT EXHAUSTING) (e.g., fast walking, baseball, tennis, easy bicycling, volleyball, badminton, easy swimming, alpine skiing, popular and folk dancing)	_____ **Enter 0 if no exercise**
c) MILD EXERCISE (MINIMAL EFFORT) (e.g., yoga, archery, fishing from river bank, bowling, horseshoes, golf, snow-mobiling, easy walking)	_____ **Enter 0 if no exercise**

2. During a typical **7-day period** (a week), in your free time (leisure time), how often do you engage in any regular activity **long enough to work up a sweat** (heart beats rapidly)? **(Please circle one choice below.)**

OFTEN SOMETIMES NEVER/RARELY

MEASUREMENTS: Please indicate your current measurements: UNK= not known

***PANT SIZE (WOMEN) _____** ***DRESS SIZE (WOMEN) _____**

***PANT WAIST SIZE (MEN) _____** ***COAT SIZE (MEN) _____**

EMOTIONAL EATING SCALE

We all respond to different emotions in different ways. Some types of feelings lead people to experience an urge to eat. **Please indicate the extent to which the following feelings lead you to feel an urge to eat by checking the appropriate box.**

	No desire to eat	A Small Desire to Eat	A Moderate Desire to Eat	A Strong Urge to Eat	An Overwhelming Urge to Eat
Resentful					
Discouraged					
Shaky					
Worn Out					
Inadequate					
Excited					
Rebellious					
Blue					
Jittery					
Sad					
Uneasy					
Irritated					
Jealous					
Worried					
Frustrated					
Lonely					
Furious					
On edge					
Confused					
Nervous					
Angry					
Guilty					
Bored					
Helpless					
Upset					

The Three-Factor Eating Questionnaire Revised 21-Item (TFEQ-R21)

Circle the answer that best describes you.

1. I deliberately take small helpings to control my weight.

(1) Definitely true, (2) Mostly true, (3) Mostly false, (4) Definitely false

2. I start to eat when I feel anxious.

(1) Definitely true, (2) Mostly true, (3) Mostly false, (4) Definitely false

3. Sometimes when I start eating, I just can't seem to stop.

(1) Definitely true, (2) Mostly true, (3) Mostly false, (4) Definitely false

4. When I feel sad, I often eat too much.

(1) Definitely true, (2) Mostly true, (3) Mostly false, (4) Definitely false

5. I don't eat some foods because they make me fat.

(1) Definitely true, (2) Mostly true, (3) Mostly false, (4) Definitely false

6. Being with someone who is eating, often makes me want to also eat.

(1) Definitely true, (2) Mostly true, (3) Mostly false, (4) Definitely false

7. When I feel tense or ''wound up'', I often feel I need to eat.

(1) Definitely true, (2) Mostly true, (3) Mostly false, (4) Definitely false

8. I often get so hungry that my stomach feels like a bottomless pit.

(1) Definitely true, (2) Mostly true, (3) Mostly false, (4) Definitely false

9. I'm always so hungry that it's hard for me to stop eating before finishing all of the food on my plate.

(1) Definitely true, (2) Mostly true, (3) Mostly false, (4) Definitely false

10. When I feel lonely, I console myself by eating.

(1) Definitely true, (2) Mostly true, (3) Mostly false, (4) Definitely false

11. I consciously hold back on how much I eat at meals to keep from gaining weight.

(1) Definitely true, (2) Mostly true, (3) Mostly false, (4) Definitely false

12. When I smell a sizzling steak or see a juicy piece of meat, I find it very difficult to keep from eating even if I've just finished a meal.

    (1) Definitely true, (2) Mostly true, (3) Mostly false, (4) Definitely false

13. I'm always hungry enough to eat at any time.

    (1) Definitely true, (2) Mostly true, (3) Mostly false, (4) Definitely false

14. If I feel nervous, I try to calm down by eating.

    (1) Definitely true, (2) Mostly true, (3) Mostly false, (4) Definitely false

15. When I see something that looks very delicious, I often get so hungry that I have to eat right away.

    (1) Definitely true, (2) Mostly true, (3) Mostly false, (4) Definitely false

16. When I feel depressed, I want to eat.

    (1) Definitely true, (2) Mostly true, (3) Mostly false, (4) Definitely false

17. How often do you avoid ''stocking up'' on tempting foods?

    (1) Almost never, (2) Seldom, (3) Usually, (4) Almost always

18. How likely are you to make an effort to eat less than you want?

    (1) Unlikely, (2) A little likely, (3) Somewhat likely, (4) Very likely.

19. Do you go on eating binges even though you're not hungry?

    (1) Never, (2) Rarely, (3) Sometimes, (4) At least once a week

20. How often do you feel hungry?

    (1) Only at mealtimes, (2) Sometimes between meals (3) Often between meals

    (4) Almost always

21. On a scale from 1 to 8, where 1 means no restraint in eating and 8 means total restraint, what number would you give yourself?

    Mark the number that best applies to you: 1 2 3 4 5 6 7 8