Trinity Behavioral Health
Robert W. Young, Ph.D.
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CONSENT TO EVALUATION & TREATMENT

This form is used to acquire informed consent to receive psychological services (i.e. evaluation and treatment). By signing this form I understand I am hereby giving my consent to participate in the evaluation process and any prescribed psychological treatment services (e.g. psychotherapy and biofeedback) as needed. I also acknowledge that I am receiving these services under my own free will and that I understand I can withdraw my consent and discontinue my participation at any time.

Therapy can help a person to gain new understanding about his or her problems and to learn new ways of coping with and solving those problems, such as anxiety, anger, depression, parenting or relationship concerns. Therapy can help a person to develop new skills and to change behavior patterns. Therapy can contribute to improved ability to cope with stress and difficult situations and can increase understanding of self and others.

I acknowledge that Dr. Young has advised me that while there are potential benefits to therapy, there is no guarantee of success and that there are potential risks. I have been advised that during therapy emotions and memories may be stimulated which can evoke strong feelings and that changes in awareness may alter my self-perceptions and ways of relating to others. I have been advised that the process of personal change can be quite varied and individual. I understand that it is important that I mention promptly any concerns or questions to Dr. Young that I may have at any time during the process of therapy.

I have been advised by Dr. Young that all communications with me and all records relating to the provision of psychological services to me are confidential and may not be disclosed without my written consent. I also am aware, and by signing this form give my consent for Dr. Young to release copies of any evaluation reports and treatment notes as needed to third party payers (i.e. insurance carriers) in order to be reimbursed for providing psychological services. I also have been advised by Dr. Young the law places certain limits on the confidential nature of the psychological services provided to me. I have been advised that these limits on confidentiality may arise if Dr. Young perceives that there is risk of harm in situations such as the following: 1) if I present an imminent danger to myself or others the law requires that steps be taken to prevent such harm; 2) if a child is in need of protection a report must be filed with the appropriate agency or authority; 3) if a vulnerable adult is abused or neglected a report may be filed with the appropriate government agency; 4) or if a court orders the disclosure of records

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As a courtesy to each patient, this office will file your insurance for you for reimbursement. In order to accomplish this, you as the patient agree to allow this office to release any personal identifying information (e.g. social security number, address etc.) necessary to the insurance carrier in order to facilitate payment. You also recognize that unless you are covered under a worker's compensation claim, any information provided from this office in order to facilitate billing and reimbursement will not include treatment records (e.g. progress notes or reports). If you are covered under a workers' compensation claim, then treatment records must be forwarded along with each reimbursement claim pursuant to federal and state law.

It also is understood and agreed that should it be necessary for this office to hire an attorney or collection agency to collect the account, the patient agrees to pay fees and all costs of collection. The patient also agrees to and understands that any account sent to collections will necessitate the release of personal identifying information, such as social security number, address etc, in order to facilitate the collection process.

I acknowledge that I have had the opportunity to carefully read this document and to ask, and have answered, any questions or concerns I have about it or arising from it. I further acknowledge that I have read and understood the information contained in this document and that it records my consent and I am aware I can receive a copy of it upon request.

Signed:

Patient Name: _____

Patient Signature: _____ Date: _____

Chronic Pain • Mood Disorders • Marriage & Family
Medical & Forensic Evaluations • Gifted & Learning Disability Assessments
Adults • Adolescents • Couples

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PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY AND SIGN:

Cancellation / No-Show Policy:

When a patient makes a late appointment cancellation, it is impossible for our office to schedule another patient in that time slot, resulting in a loss of revenue. Because of this, it is necessary to assess a **$100 fee** for any cancellations not completed within 24-hours of the scheduled appointment. All **no-show appointments** are automatically assessed the **$100 fee**. There are no exceptions to the no-show policy. No-show appointments will always be assessed the $100 no-show fee.

Credit Card / Debit Card Processing

When you use a credit card or debit card the charge will be under Trinity Behavioral Health. Additionally, there will be a 4% additional fee added to the amount due to cover the fee for processing the credit card charge.

Financial Responsibility

Due to high cost of health care, payment is due at time of service. As a courtesy to each patient, your insurance company will be billed directly. Should your insurance company deny or make only a partial payment, the patient WILL be responsible for the balance due. Please also note, it is understood and agreed that should it be necessary to hire an attorney or collection agency to collect on a patient's account, the patient agrees to pays all fees and costs of collection, to include those of an attorney if one is necessary.

Thank you for your understanding.

Robert W. Young, Ph.D.

_____ _____

Patient Signature Date

Chronic Pain • Mood Disorders • Marriage & Family
Medical & Forensic Evaluations • Gifted & Learning Disability Assessments
Adults • Adolescents • Couples

BDI-II

Date:

Name: _____ Marital Status: _____ Age: _____ Sex: _____

Occupation: _____ Education: _____

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today.** Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness
- 0 I do not feel sad.
- 1 I feel sad much of the time.
- 2 I am sad all the time.
- 3 I am so sad or unhappy that I can't stand it.

2. Pessimism
- 0 I am not discouraged about my future.
- 1 I feel more discouraged about my future than I used to be.
- 2 I do not expect things to work out for me.
- 3 I feel my future is hopeless and will only get worse.

3. Past Failure
- 0 I do not feel like a failure.
- 1 I have failed more than I should have.
- 2 As I look back, I see a lot of failures.
- 3 I feel I am a total failure as a person.

4. Loss of Pleasure
- 0 I get as much pleasure as I ever did from the things I enjoy.
- 1 I don't enjoy things as much as I used to.
- 2 I get very little pleasure from the things I used to enjoy.
- 3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings
- 0 I don't feel particularly guilty.
- 1 I feel guilty over many things I have done or should have done.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6. Punishment Feelings
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7. Self-Dislike
- 0 I feel the same about myself as ever.
- 1 I have lost confidence in myself.
- 2 I am disappointed in myself.
- 3 I dislike myself.

8. Self-Criticalness
- 0 I don't criticize or blame myself more than usual.
- 1 I am more critical of myself than I used to be.
- 2 I criticize myself for all of my faults.
- 3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes
- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10. Crying
- 0 I don't cry anymore than I used to.
- 1 I cry more than I used to.
- 2 I cry over every little thing.
- 3 I feel like crying, but I can't.

_____ Subtotal Page 1

Continued on Back

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11. Agitation

0 I am no more restless or wound up than usual.

1 I feel more restless or wound up than usual.

2 I am so restless or agitated that it's hard to stay still.

3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.

1 I am less interested in other people or things than before.

2 I have lost most of my interest in other people or things.

3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.

1 I find it more difficult to make decisions than usual.

2 I have much greater difficulty in making decisions than I used to.

3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.

1 I don't consider myself as worthwhile and useful as I used to.

2 I feel more worthless as compared to other people.

3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.

1 I have less energy than I used to have.

2 I don't have enough energy to do very much.

3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.

1a I sleep somewhat more than usual.

1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.

2b I sleep a lot less than usual.

3a I sleep most of the day.

3b I wake up 1–2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.

1 I am more irritable than usual.

2 I am much more irritable than usual.

3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.

1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.

2b My appetite is much greater than usual.

3a I have no appetite at all.

3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.

1 I can't concentrate as well as usual.

2 It's hard to keep my mind on anything for very long.

3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.

1 I get more tired or fatigued more easily than usual.

2 I am too tired or fatigued to do a lot of the things I used to do.

3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.

1 I am less interested in sex than I used to be.

2 I am much less interested in sex now.

3 I have lost interest in sex completely.

12 ABCDE

____ Subtotal Page 2

____ Subtotal Page 1

____ Total Score

BAI®

NAME _____ DATE _____

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to each symptom.

		NOT AT ALL	MILDLY (It did not bother me much)	Moderately (It was very unpleasant but I could Stand it)	SEVERELY (I could Barely Stand it)
1. Numbness or tingling.	1.				
2. Feeling hot.	2.				
3. Wobbliness in legs.	3.				
4. Unable to relax.	4.				
5. Fear of the worst happening.	5.				
6. Dizzy or lightheaded.	6.				
7. Heart pounding or racing.	7.				
8. Unsteady.	8.				
9. Terrified.	9.				
10. Nervous.	10.				
11. Feelings of choking.	11.				
12. Hands trembling.	12.				
13. Shaky.	13.				
14. Fear of losing control.	14.				
15. Difficulty breathing.	15.				
16. Fear of dying.	16.				
17. Scared.	17.				
18. Indigestion or discomfort in abdomen	18.				
19. Faint.	19.				
20. Face flushed.	20.				
21. Sweating (not due to heat).	21.				

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San Diego • Philadelphia • Austin • Fort Worth • Toronto • London

The Weight and Lifestyle Inventory (WALI) is designed to obtain information about your weight and dieting histories, your eating and exercise habits, and your relationships with family and friends. Please complete the questionnaire carefully and make your best guess when unsure of the answer. You will have an opportunity to review your answers with a member of our professional staff.

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

SECTION A: IDENTIFYING INFORMATION

_____
[1] Name

_____ _____ _____lbs. _____ft. _____inches
[2] Date of Birth [3] Age [4] Weight [5] Height

_____
[6] Address

_____ _____ _____/_____ yrs.
[7] Phone: Cell [8] Phone: Home [9] Occupation/# of yrs. at job

_____
[10] Today's Date

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

□ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ 12 □ 13 □ 14 □ 15 □ 16 □ Masters □ Doctorate
Middle School High School College

[12] Race (Check all that apply): □ American Indian □ Asian □ African American/Black
□ Pacific Islander □ White □ Other: _____

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

SECTION B: WEIGHT HISTORY

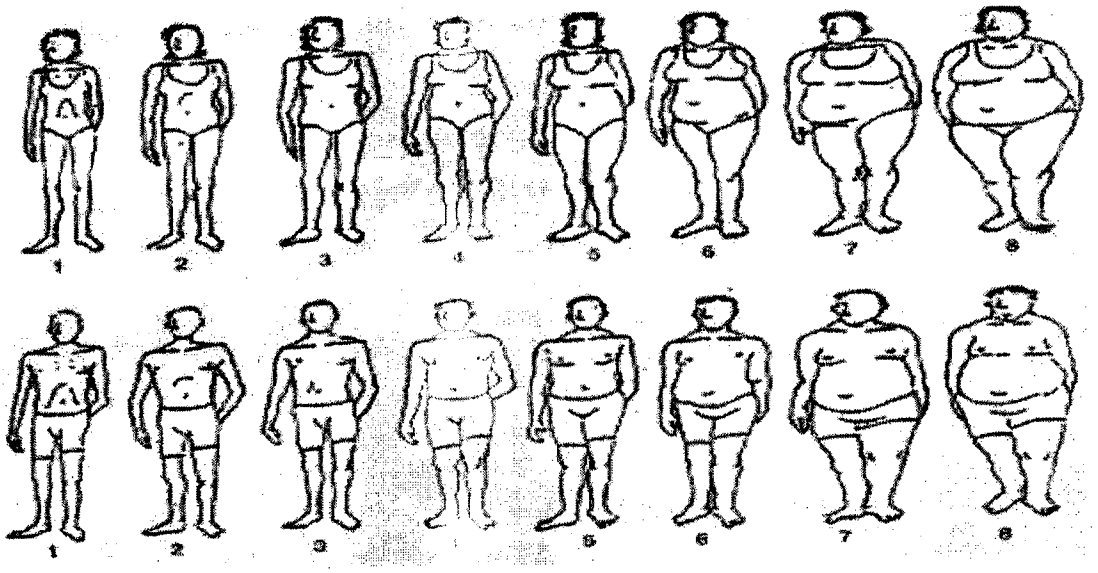
1. At what age were you first overweight by 10 lbs. or more? _____ yrs. old
2. What has been your highest weight after age 21? _____ lbs. _____ yrs. old at the time
3. What has been your lowest weight (not due to illness) after age 21, which you have maintained for at least 1 year? _____ lbs. _____ yrs. old, maintained for _____ yrs.

For office use:

Interviewer: _____ Date of interview: _____

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

	AGE	MAXIMUM WEIGHT	FIGURE #	EVENTS 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.	60-70	_____	_____	_____



SECTION C: FAMILY WEIGHT HISTORY

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

Parent	Height (ft.+in.)	Weight (lbs.)	Current Age (or year of death)	Figure # (from previous page)
a. Mother	_____	_____	_____	_____
b. Father	_____	_____	_____	_____

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

c. Spouse/ Significant Other	_____	_____	_____	_____

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

Your mother's mother: □ Yes □ No □ DK Your father's mother: □ Yes □ No □ DK
Your mother's father: □ Yes □ No □ DK Your father's father: □ Yes □ No □ DK

3. How many brothers do you have (who are biologically related to you)? _____
How many are (were) overweight or obese? _____

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

SECTION D: WEIGHT, PREGNANCY, AND MENSTRUAL CYCLE

(For Women Only)

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

If yes,

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

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

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

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

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

2. Do you experience a regular menstrual cycle? □ Yes □ No
   If yes, describe your eating around the time of your menstruation. (Check one)
   □ Eat much less □ Eat less □ No Change □ Eat More □ Eat Much More

SECTION E: WEIGHT LOSS HISTORY

1. Please record your major weight loss efforts, (e.g., diet, exercise, medication, etc.) which resulted in a weight loss of 10 pounds or more. Take time to think over your previous efforts, starting with the first one, whether in childhood or adulthood. You may have difficulty remembering this information at first, but most people can if they take their time. Start with your first weight loss effort and proceed in order. If you have had more than seven efforts on which you lost 10 pounds or more, please list your largest losses.

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

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

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

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

   1. _____ 2. _____ 3. _____

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

   1. _____ 2. _____ 3. _____

SECTION F: WEIGHT LOSS GOALS

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

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

3. At what age did you last weigh this amount? _____ years

SECTION G: TOBACCO AND ALCOHOL USE

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

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

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

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

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

   _____

   _____

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

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

   _____

   _____

SECTION H: EATING HABITS

1. Please check the behaviors below that are a problem for you and which you believe contribute to weight gain.

□ Overeating at breakfast
□ Overeating at lunch
□ Overeating at dinner
□ Snacking between meals
□ Snacking after dinner
□ Eating because I feel physically hungry
□ Eating because I crave certain foods
□ Continuing to eat because I don't feel full after a meal
□ Eating because I can't stop once I've begun
□ Eating because of the good taste of foods
□ Eating while cooking or preparing food
□ Eating when anxious
□ Eating when tired or bored
□ Eating when stressed or angry
□ Eating when depressed or upset
□ Eating when socializing/celebrating
□ Eating when alone
□ Eating with family or friends
□ Eating at business functions

Please describe any other factors that contribute significantly to your gaining weight.

_____

_____

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

   a. Breakfast _____ days a week Time: _____ Morning Snack _____ days a week Time: _____

   b. Lunch _____ days a week Time: _____ Afternoon Snack _____ days a week Time: _____

   c. Dinner _____ days a week Time: _____ Evening Snack _____ days a week Time: _____

3. Who prepares meals at your home? _____

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

_____ skim milk	_____ low-fat milk	_____ whole milk	_____energy drinks	____ other diet drinks
_____ fruit juice	_____ diet soda	_____ tea	_____coffee	
_____ water	_____ regular soda	_____ wine	_____ sports drinks	

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

   Breakfast _____ meals a week

   Lunch _____ meals a week

   Dinner _____ meals a week

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

   Breakfast _____ meals a week

   Lunch _____ meals a week

   Dinner _____ meals a week

SECTION I: FOOD INTAKE RECALL

Please indicate the foods you consume on a typical day.

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

SECTION J: EATING PATTERNS I

The Questionnaire on Eating and Weight Patterns-5 is reprinted here with permission from Yanovski, S.Z., Marcus, M.D., Wadden, T.A. and Walsh, B.T., 2014. (Reprinted in the Int J Eating Disorders 2015.)

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

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

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

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

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

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

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

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

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

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

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

FOOD	AMOUNT	BRAND (if possible)

d. At the time this episode started, how long had it been since you had previously finished eating a meal or snack?

_____ hours _____ minutes

6. In general, during the past **three months**, how upset were you by these episodes (when you ate a large amount of food and felt your eating was out of control)?

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

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

If Yes: How often, **on average,** was that?
- □ Less than 1 episode per week
- □ 1 episode per week
- □ 2-3 episodes per week
- □ 4-7 episodes per week
- □ 8-13 episodes per week
- □ 14 or more episodes per week

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

If Yes: How often, **on average**, was that?
- □ Less than 1 time per week
- □ 1 time per week
- □ 2-3 times per week
- □ 4-5 times per week
- □ 6-7 times per week
- □ 8 or more times per week

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

If Yes: How often, **on average**, was that?
- □ Less than 1 time per week
- □ 1 time per week
- □ 2-3 times per week
- □ 4-5 times per week
- □ 6-7 times per week
- □ 8 or more times per week

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

If Yes: How often, **on average**, was that?
- □ Less than 1 day per week
- □ 1 day per week
- □ 2 days per week
- □ 3 days per week
- □ 4-5 days per week
- □ More than 5 days per week

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

If Yes: How often, **on average,** was that?
- □ Less than 1 time per week
- □ 1 time per week
- □ 2-3 times per week
- □ 4-7 times per week
- □ 8-13 times per week
- □ 14 or more times per week

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

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

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

13. During the past **three months**, on average, how important has your weight or shape been in how you feel about or evaluate yourself as a person – as compared to other aspects of your life, such as your performance at work or as a parent, or how you get along with other people?

- □ Weight and shape were **not very important**
- □ Weight and shape **played a part** in how you felt about yourself
- □ Weight and shape **were among the main things** that affected how you felt about yourself
- □ Weight and shape **were the most important things** that affected how you felt about yourself

14. During the past **three** months, did you ever have episodes during which you felt you could not stop eating or control what or how much you were eating but in which you did ***not*** consume what most people would think was an unusually large amount of food? □ Yes □ No

IF NO, SKIP TO SECTION K. Do not complete questions 15-18.

15. During the past **three** months how often did you have episodes like this -- the feeling that your eating was out of control, but you did ***not*** consume what most people would think was an unusually large amount of food? (There may have been some weeks when this did not happen --just average those in.)

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

16. Did you **usually** have any of the following experiences during these episodes?

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

17. Think about a **typical** episode when you ate this way (that is, when you felt you could not stop eating or control what or how much you were eating) but in which you did ***not*** consume an unusually large amount of food):

a. What time of day did the episode start?

- □ (8 AM to 12 Noon)
- □ (12 Noon to 4 PM)
- □ (4 PM to 8 PM)
- □ (8 PM to 12 Midnight)
- □ (12 Midnight to 8 AM)

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

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

FOOD	AMOUNT	BRAND (if possible)

d. At the time this episode started, how long had it been since you had previously finished eating a meal or snack?
____ hours ____ minutes

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

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

SECTION K: EATING PATTERNS II
The Night Eating Questionnaire is reprinted with permission of: Allison, K.C., Stunkard, A.J., and Thier, S.L. (2004).

Directions: Please **check one answer** for each question.

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

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

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

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

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

6. Are you currently feeling blue or down in the dumps?
□ Not at all □ A little □ Somewhat □ Very much so □ Extremely

7. When you are feeling blue, is your mood lower in the:
□ Early morning □ Late morning □ Afternoon
□ Early evening □ Late evening/nighttime
□ Check here if your mood does not change during the day

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

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

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

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

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

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

********** *IF "NEVER" ON #12, PLEASE SKIP TO #15* **********

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

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

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

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

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

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

SECTION L: PHYSICAL ACTIVITY

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

2. Do you have any physical problems that limit your physical activity? □ Yes □ No
If yes, please describe. _____

3. Please check the types of physical activity that you have engaged in during the past six months.

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

4. What is your most frequent physical activity? _____
   How many times per week do you engage in this activity? _____ times/week
   How many minutes per week do you engage in this activity? _____ minutes/week

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

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

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

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

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

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

SECTION M: FAMILY AND LIVING ARRANGEMENTS

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

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

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

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

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

   Please describe briefly what this person does either to help or hinder your efforts to lose weight.

   _____

   _____

5. How satisfied are you with your overall relationship with this person? (Check one)
   □ very satisfied □ satisfied □ neutral □ dissatisfied □ very dissatisfied

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

   _____

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

   _____

SECTION N: SELF-PERCEPTIONS

1. How satisfied are you with your current weight? (Check one)

   □ very satisfied
   □ somewhat satisfied
   □ neutral
   □ somewhat dissatisfied
   □ very dissatisfied

2. How satisfied are you with your current overall appearance? (Check one)

   □ very satisfied
   □ somewhat satisfied
   □ neutral
   □ somewhat dissatisfied
   □ very dissatisfied

3. Pick the one sentence that best describes your overall feelings about yourself. "In general, I am..." (Check one)

   □ very happy with who I am
   □ happy with who I am
   □ ok with who I am but have some mixed feelings
   □ unhappy with who I am
   □ very unhappy with who I am

4. "As compared with most people, I think I have..." (Check one)

   □ very good self-esteem
   □ good self-esteem
   □ average self-esteem
   □ poor self-esteem
   □ very poor self-esteem

SECTION O: PSYCHOLOGICAL FACTORS

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

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

Problem	Year	Duration (wks.)	Type of Professional Help
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

3. Have you ever been hospitalized for a psychiatric condition? □ Yes □ No
If yes, describe below.

Problem	Year	Duration (wks.)	Type of Professional Help
_____	____	_____	_____
_____	____	_____	_____

4. Have you ever tried to physically harm yourself? □ Yes □ No
If yes, describe below.

_____

_____

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

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

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

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

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

SECTION P: TIMING

1. Please indicate if you are currently experience any greater than usual stress in your life related to the following events. Complete each item by checking the appropriate box.

a. Work: □ Yes □ No

b. Health: □ Yes □ No

c. Relationship with significant other: □ Yes □ No

d. Activities related to your children: □ Yes □ No

e. Activities related to your parents: □ Yes □ No

f. Legal/financial trouble: □ Yes □ No

g. School: □ Yes □ No

h. Moving: □ Yes □ No

i. Other: _____

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

_____

_____

_____

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

   If yes, please briefly describe below:

   _____

   _____

   _____

3. How stressful has your life been during the past 6 months? (Check one.)

   □ much less stressful than usual
   □ less stressful than usual
   □ average level of stress
   □ more stressful than usual
   □ much more stressful than usual

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

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

   _____

   _____

   _____

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

   _____

   _____

7. Rate how confident you are that you will be able to significantly change your eating and exercise habits. Pick a number from 1 to 10 in which 1 = not all confident and 10 = extremely confident. Your number is: _____

SECTION Q: PREPARING FOR BARIATRIC SURGERY

1. Have you started separating your meals and drinks by 30 minutes? □ Yes □ No
   Has this been difficult? Describe how you've been doing this.

   _____

   _____

2. Do you understand why we ask you to separate meals and drinks? □ Yes □ No
3. Do you consider yourself a fast or slow eater? □ Fast □ Slow
4. About how long does it take you to eat a meal? (Check one)
   □ less than 20 minutes □ 20-30 minutes □ more than 30 minutes
5. Have you been practicing chewing your food well (until almost pureed consistency)? □ Yes □ No
6. Do you know how many grams of protein per day you are aiming to consume? _____

If having gastric bypass:

7. Do you know what types of food cause dumping syndrome? (Check one)
   □ I don't know □ High fat □ High sugar
8. Do you know how many grams of sugar you are aiming to stay below for each meal or snack? ____

SECTION R: MEDICAL HISTORY

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

	YES	NO
Heart Disease		
Angina (chest pains)		
Palpitations, heart beats fast or hard		
Stroke, mild stroke (cerebrovascular accident)		
Rheumatic fever		
Heart murmur		
Pacemaker		
Breathing problems (asthma, lung disease)		
High blood pressure		
Anemia		
Back problems		
Joint or bone problems		
Hiatal hernia		
Arthritis		
Gout (elevated uric acid)		
Gallbladder disease		
Thyroid problems		
Kidney disease		
Cancer (specify type)		
Ulcers		
Bowel disease		
Gastric Esophageal Reflux Disease (GERD)		
Liver disease		
Diabetes (type I or II)		
Sleep Apnea		
Bodily pain		
Other (specify)		

2. List all prescription medications you currently take. Please indicate the dosage and frequency (number of times a day) of each medication.

Medication	Dosage	Frequency	Reason for taking

Please indicate your primary care practitioner's name, telephone number, and address here.

Name: _____ Tel: _____

Address: _____

_____

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

ID: **Date:**

EATING QUESTIONNAIRE

Instructions: The following questions are concerned with the past four weeks (28 days) only. Please read each question carefully. Please answer all of the questions. Please only choose one answer for each question. Thank you.

Questions 1 to 12: Please circle the appropriate number on the right. Remember that the questions only refer to the past four weeks (28 days) only.

	On how many of the past 28 days	No days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Every day
1	Have you been deliberately trying to limit the amount of food you eat to influence your shape or weight (whether or not you have succeeded)?	0	1	2	3	4	5	6
2	Have you gone for long periods of time (8 waking hours or more) without eating anything at all in order to influence your shape or weight?	0	1	2	3	4	5	6
3	Have you tried to exclude from your diet any foods that you like in order to influence your shape or weight (whether or not you have succeeded)?	0	1	2	3	4	5	6
4	Have you tried to follow definite rules regarding your eating (for example, a calorie limit) in order to influence your shape or weight (whether or not you have succeeded)?	0	1	2	3	4	5	6
5	Have you had a definite desire to have an empty stomach with the aim of influencing your shape or weight?	0	1	2	3	4	5	6
6	Have you had a definite desire to have a totally flat stomach?	0	1	2	3	4	5	6
7	Has thinking about food, eating or calories made it very difficult to concentrate on things you are interested in (for example, working, following a conversation, or reading)?	0	1	2	3	4	5	6
8	Has thinking about shape or weight made it very difficult to concentrate on things you are interested in (for example, working, following a conversation, or reading)?	0	1	2	3	4	5	6
9	Have you had a definite fear of losing control over eating?	0	1	2	3	4	5	6
10	Have you had a definite fear that you might gain weight?	0	1	2	3	4	5	6
11	Have you felt fat?	0	1	2	3	4	5	6
12	Have you had a strong desire to lose weight?	0	1	2	3	4	5	6

Questions 13-18: Please fill in the appropriate number in the boxes on the right. Remember that the questions only refer to the past four weeks (28 days).

Over the past four weeks (28 days).....

13	Over the past 28 days, how many times have you eaten what other people would regard as an unusually large amount of food (given the circumstances)?	.....
14	....On how many of these times did you have a sense of having lost control over your eating (at the time that you were eating)?	.....
15	Over the past 28 days, on how many **DAYS** have such episodes of overeating occurred (i.e. you have eaten an unusually large amount of food and have had a sense of loss of control at the time)?	.....
16	Over the past 28 days, how many times have you made yourself sick (vomit) as a means of controlling your shape or weight?	.....
17	Over the past 28 days, how many times have you taken laxatives as a means of controlling your shape or weight?	.....
18	Over the past 28 days, how many times have you exercised in a "driven" or "compulsive" way as a means of controlling your weight, shape or amount of fat or to burn off calories?	.....

Questions 19-21: Please circle the appropriate number. Please note that for these questions the term "binge eating" means eating what others would regard as an unusually large amount of food for the circumstances, accompanied by a sense of having lost control over eating.

19	Over the past 28 days, on how many days have you eaten in secret (ie, furtively)?.....Do not count episodes of binge eating	No days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Every day
		0	1	2	3	4	5	6
20	On what proportion of the times that you have eaten have you felt guilty (felt that you've done wrong) because of its effect on your shape or weight? .....Do not count episodes of binge eating	None of the times	A few of the times	Less than half	Half of the times	More than half	Most of the time	Every time
		0	1	2	3	4	5	6
21	Over the past 28 days, how concerned have you been about other people seeing you eat? .....Do not count episodes of binge eating	Not at all		Slightly	Moderately			Markedly
		0	1	2	3	4	5	6

Questions 22-28: Please circle the appropriate number on the right. Remember that the questions only refer to the past four weeks (28 days)

	On how many of the past 28 days	Not at all		Slightly		Moderately		Markedly
22	Has your weight influenced how you think about (judge) yourself as a person?	0	1	2	3	4	5	6
23	Has your shape influenced how you think about (judge) yourself as a person?	0	1	2	3	4	5	6
24	How much would it have upset you if you had been asked to weigh yourself once a week (no more, or less, often) for the next four weeks?	0	1	2	3	4	5	6
25	How dissatisfied have you been with your weight?	0	1	2	3	4	5	6
26	How dissatisfied have you been with your shape?	0	1	2	3	4	5	6
27	How uncomfortable have you felt seeing your body (for example, seeing your shape in the mirror, in a shop window reflection, while undressing or taking a bath or shower)?	0	1	2	3	4	5	6
28	How uncomfortable have you felt about others seeing your shape or figure (for example, in communal changing rooms, when swimming, or wearing tight clothes)?	0	1	2	3	4	5	6

What is your weight at present? (Please give your best estimate). .....

What is your height? (Please give your best estimate). .....

If female: Over the past three-to-four months have you missed any menstrual periods? .....

If so, how many? .....

Have you been taking the "pill"? .....

THANK YOU