



Duke Diet & Fitness

501 Douglas Street, Durham, NC 27705
1-800-235-3853

BEHAVIORAL HEALTH SCREENING FORM

Please take a moment to complete the following: If you are uncomfortable answering any of these questions, leave them blank and we can discuss them in person.

We have done our best not to repeat questions included in the Medical Questionnaire however, in order to get the most comprehensive assessment for our purposes, it has been necessary to have some repetition.

Please answer each item even if you are not completely sure of the answer.

DEMOGRAPHIC INFORMATION

Name: _____ Date: _____ Gender: Male Female Age: _____

Where do you live? _____ Date of Birth _____ Length of DFC visit _____ week(s)

Marital Status: Married Single Cohabiting Divorced Separated Widowed

Live with whom? Alone Partner/spouse Partner / spouse & children Parent/other relatives Other

If you have children: How many are living with you? _____ Age/gender(s) _____

How many are not living with you? _____ Age/genders(s) _____

Highest level of education attained (Check one)

Attended Grammar school Completed grammar school (8th grade) Attended high school (did not complete)

GED Graduated high school Attended college (did not complete) Graduated college

Some post graduate Masters Doctorate MD

Employment: Full-time Part-time Unemployed Disability Retired Student Homemaker

Occupation: _____ Average hours / week worked _____

MEDICAL INFORMATION

Have you ever experienced a head injury? Yes No

Did you lose consciousness? Yes No How Long? _____ minutes / hours / days (circle one)

Did you have a concussion? Yes No

Current Medications:

Anti-ulcer Anti-arthritis Blood pressure Diabetes Pain Cardiac Antidepressant Anti-anxiety

Anti-obesity List: _____ Other (list) _____

Reproductive status (women only):

- Post-menopausal Menopausal Post-hysterectomy Pre-menopausal (**using** birth control)
 Pre-menopausal (**NOT** using birth control)

WEIGHT AND DIETING HISTORY

What is your current weight _____ Height _____ feet _____ inches.

Why are you trying to lose weight **now** (you may check more than one)?

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> Health | <input type="checkbox"/> Doctor suggested I lose weight |
| <input type="checkbox"/> Mobility | <input type="checkbox"/> Other person suggested I lose weight (e.g., friend, spouse) |
| <input type="checkbox"/> Appearance | <input type="checkbox"/> Other (Please list: _____) |

Do you have a family history of obesity (e.g. parents, brothers, and sisters) Yes No

During what period of your life did you **first** begin to have difficulty with your weight?

- Toddler years Childhood Adolescence Young adult (Age ____) Late adult (Age ____)

As a child, were you teased about your weight? Yes No

What has been your lowest weight since age 18? _____ At what age(s) _____

What was your highest weight since age 18? _____ At what age(s) _____

What is the most weight you have lost as an adult? _____ How long did it take? _____ Years _____ Months

How long did you maintain that weight loss? _____ Years _____ Months.

Over the last 6 months have you:

Gained weight ? No Yes If Yes, How much _____?

Lost weight? No Yes If so When? _____ month (s) ago How much? _____ lbs.

What factors have contributed significantly to your weight difficulty (**check all** that apply)?

- Illness/injury Pregnancy Social eating Business eating Weight control not a priority Death of a loved one Genetic Slow metabolism Family commitments Work commitments Overeating
 Lack of Exercise Emotions (boredom, sadness, anxiety, stress) Lack of time Relationship Factors
Other (list) _____

Circle the ONE above that you feel contributes the most to your weight difficulty **right now**.

Please indicate weight loss programs and diets you have tried.

- "Weight Watchers" Overeaters Anonymous "Jenny Craig - Nutri-System" Meal Replacements (e.g. "Slim Fast") VLCD (no food - all shakes or nutrition bars) Duke Diet and Fitness Center

- Other residential programs (Pritikin, Rice House, Structure House) Exercise and diet (self-directed). Low Carbohydrate Other Physician-directed diet plans Dietitian Gym Personal trainer (continued...)
- Weight loss surgery: Type (if known) _____ What year? _____
- Prescription weight loss medication (list) _____
- Over-the-counter weight loss aids (e.g. herbal supplements)(list) _____
- Other (list) _____

What is the longest that you have maintained any weight loss of 10 pounds or more? ____ Years ____ Months

How many times (approximately) have you lost 10 lbs or more—when you weren't sick—and then gained it back (excluding childbirth)?

- 1 Never
- 2 Once or twice
- 3 Three or four times
- 4 Five times or more

Do you engage in regular physical activity?

Aerobic No Yes: ____ times / week for ____ min. each time.

Strength/stretching No Yes: ____ times / week for ____ .

Circle the number that best describes how you feel about each of the following:

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

1 2 3 4 5

Not Motivated Slightly Motivated Somewhat Motivated Quite Motivated Extremely Motivated

2. How certain are you that you will stay committed to a weight loss program for the time it will take to reach your goal?

1 2 3 4 5

Not Certain Slightly Certain Somewhat Certain Quite Certain Extremely Certain

3. Consider all outside factors in your life (work-stress, family obligations, etc.). To what extent can you tolerate the effort required to stick to a weight loss program.

1 2 3 4 5

Not Certain Slightly Certain Somewhat Certain Quite Certain Extremely Certain

What is your average **weekly** weight loss goal while at the DFC ? _____ lbs. do not have weekly goal

EATING PATTERNS

For each meal, indicate how many times you eat out per week?

	0-1	2-3	4-5	6-7
Breakfast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lunch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dinner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What are your reasons for eating out (check all that apply)?

Convenience Business Can't cook Dislike cooking Socializing other (list) _____

1. During the past six months, did you often eat within any two-hour period what most people would regard as an unusually large amount of food? Yes No

IF "NO," PLEASE SKIP TO QUESTION # 6

2. During the times when you ate this way, did you often feel you couldn't stop eating or control what or how much you were eating?" Yes No

IF "NO," PLEASE SKIP TO QUESTION # 6

3. Did you usually have any of the following experiences during these occasions (listed in 1 or 2 above)?

a) Eating much more rapidly than usual Yes No

b) Eating until you felt uncomfortably full Yes No

c) Eating large amounts of food when you didn't feel physically hungry 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

4. In general during the past 6 months, how upset were you by the feeling that you couldn't stop eating or control what or how much you were eating?

Not at all Slightly Moderately Greatly Extremely

5. During the past six months, how often, on average, did you have times when you ate that way? – That is, large amounts of food plus feeling your eating was out of control? (There may have been some weeks when this was not present. Just average those in.)

- 1 Less than 1 day a week
- 2 One day a week
- 3 Two or three days a week
- 4 Four or five days a week (cont...)

- 5 Nearly every day
 6 Daily

Please describe the amount of food consumed during one of these episodes (Question 5 above) .

6. During the last six months, did you make yourself vomit or use laxatives to lose weight or avoid gaining weight ? Yes No

IF YES: How often, on average, was that?

- 1 Less than 1 day a week
 2 One day a week
 3 Two or three days a week
 4 Four or five days a week
 5 Nearly every day
 6 Daily

7. Have you ever made yourself vomit or use laxatives to lose weight or avoid gaining weight?

Yes No If so when was the last time? _____ years _____ months

8. During the last six months, did you fast for one day or more to control your weight? Yes No

IF YES: For how long, and how often per month? _____ hours _____ # of times

Was this a total fast (no food at all)? Yes No

9. Have you **ever** done a fast for one day or more to control your weight?

Yes No If so when was the last time? _____ years _____ months ago.

SOCIAL SUPPORT

Are members of your household aware that you are starting this program? Yes No

Are they supportive? Yes No

How stressful is your household?

1	2	3	4	5
Very	Somewhat	A little	Not too	Not at
Stressful	Stressful	Stressful	Stressful	all Stressful

If you are working, are your co-workers aware that you are starting this program? Yes No

Are they supportive? Yes No

How stressful is your work environment?

1	2	3	4	5
Very Stressful	Somewhat Stressful	A little Stressful	Not too Stressful	Not at all Stressful

OTHER BEHAVIORAL ITEMS

Do you smoke **now**? No Yes _____ cigarettes per day.

Are you a **former** smoker? No Yes _____ cigarettes per day. Quit how long? ____Years ____ Months

If **yes** to **either** of the above, please indicate the total number of years smoked _____

Do you drink alcohol **now**? No Yes ____ drinks per week.

Indicate the number of each of the following per week:

_____ Wine (1 glass = 4 oz) _____ Beer (12 oz can/bottle) _____ Hard Liquor (cocktails/shots (1 drink = 1 oz liquor)

Has anyone ever expressed concern about your drinking? Yes No

Are you a **former** drinker? No Yes _____ drinks per week. Quit how long? _____ months/years

How much of the following caffeinated beverages do you drink per day?

_____ Cup(s) of coffee (cup = 6 oz) _____ Cup(s) of tea (cup = 6oz) _____ Can/bottle soda (1 can = 12 oz)

Do you use any recreational drugs (e.g., marijuana, cocaine)? Yes No

If yes how often per week? ____ Please list substances used _____

If quit how long? ____years ____months

Have you ever sought or participated in counseling (psychologist, psychiatrist, counselor) in the past? Yes No

If so please give more detail (include for what you were treated).

Which of the following best describes how you feel about your appearance?

- I am extremely satisfied with my appearance.
- I am generally satisfied with my appearance.
- I am somewhat satisfied and somewhat dissatisfied with my appearance.
- I am generally dissatisfied with my appearance.
- I am extremely dissatisfied with my appearance.

Do your feelings about your appearance interfere with your day-to-day activities? Yes No

If so, please describe:

Please indicate on a **scale from 1-10** (10 being very relevant) how relevant each of the following Diet and Fitness Center components are to your needs: Medical _____, Nutrition _____, Fitness _____, Behavioral Health _____ Lifestyle Coaching (Follow-up Program) _____

Please provide any other comments that you feel are relevant:

In the pages that follow you will find several brief questionnaires that will be helpful in evaluating you in relation to your lifestyle change efforts and will be used to help design your behavioral program at the Duke Diet & Fitness Center. Please answer as fully and accurately as you can.

Please mark each of the questions below either “yes” or “no.”

We would like to ask you a series of questions about some things people sometimes experience. We ask every client these questions to see if there are additional areas in which we can be helpful.

- 1) Have you ever had a period of one week or more during which you became so extremely excited, or happy or irritable that you got into trouble, or your family and friends worried about it, or you were taken to see a doctor?
 Yes No
- 2) Have you ever seen, heard, or smelled things that others could not? Yes No
- 3) Have you ever had thoughts that others were trying to harm you or were out to get you? Yes No
- 4) Have you ever experienced severe distress or anxiety from thoughts, images, or impulses that worked their way into your mind? Yes No
 - i. If so, did you try to ignore the thoughts, images, or impulses? Yes No
 - ii. Did you believe that the thoughts, images, or impulses were a product of your own mind? Yes
 No
- 5) Have you found yourself performing certain behaviors (such as washing your hands, checking things) or mental acts (such as counting) over and over again for no good reason? Yes No
- 6) If so, did you perform the behaviors or mental acts in order to prevent a dreaded event or situation from occurring? Yes No
- 7) Have you ever experienced significant trauma such as car accident, physical, emotional or sexual abuse?
 Yes No
 - A. Do you feel you “re-experience” the traumatic event by experiencing dreams or recollections of the event?
 Yes No
 - B. Do you experience a physical or psychological reaction to things that remind you of the event?
 Yes No
 - C. Do you avoid things that remind you of the event? Yes No
- 8) Have you ever had thoughts of killing yourself? Yes No ii) Attempted suicide? Yes No

Please use this space for additional comments:

Hospital Anxiety and Depression Scale (HADS)

Read each item below and check the reply, which comes closest to how you have been feeling in the **past week**. Don't take too long over your replies; your immediate reaction to each item will probably be more accurate than a long, thought-out response. **Circle the most appropriate number** (0, 1, 2, or 3) for each item.

A	<p><i>I feel tense or 'wound' up:</i></p> <p>3 - Most of the time 2 - A lot of the time 1 - From time to time, occasionally 0 - Not at all</p>	D	<p><i>I feel as if I am slowed down:</i></p> <p>3 - Nearly all the time 2 - Very often 1 - Sometimes 0 - Not at all</p>
D	<p><i>I still enjoy the things I used to enjoy:</i></p> <p>0 - Definitely as much 1 - Not quite so much 2 - Only a little 3 - Hardly at all</p>	A	<p><i>I get a sort of frightened feeling like 'butterflies' in the stomach:</i></p> <p>0 - Not at all 1 - Occasionally 2 - Quite often 3 - Very often</p>
A	<p><i>I get a sort of frightened feeling as if something awful is about to happen:</i></p> <p>3 - Very definitely and quite badly 2 - Yes, but not too badly 1 - A little, but it doesn't worry me 0 - Not at all</p>	D	<p><i>I have lost interest in my appearance:</i></p> <p>3 - Definitely 2 - I don't take as much care as I should 1 - I may not take quite as much care 0 - I take just as much care as ever</p>
D	<p><i>I can laugh and see the funny side of things:</i></p> <p>0 - As much as I always could 1 - Not quite so much now 2 - Definitely not so much now 3 - Not at all</p>	A	<p><i>I feel restless as I have to be on the move:</i></p> <p>3 - Very much indeed 2 - Quite a lot 1 - Not very much 0 - Not at all</p>
A	<p><i>Worrying thoughts go through my mind:</i></p> <p>3 - A great deal of the time 2 - A lot of the time 1 - Not too often 0 - Very little</p>	D	<p><i>I look forward with enjoyment to things:</i></p> <p>0 - As much as I ever did 1 - Rather less than I used to 2 - Definitely less than I used to 3 - Hardly at all</p>
D	<p><i>I feel cheerful:</i></p> <p>3 - Never 2 - Not often 1 - Sometimes 0 - Most of the time</p>	A	<p><i>I get sudden feelings of panic:</i></p> <p>3 - Very often indeed 2 - Not very often 1 - Hardly at all 0 - Not at all</p>
A	<p><i>I can sit at ease and feel relaxed</i></p> <p>0 - Definitely 1 - Usually 2 - Not often 3 - Not at all</p>	D	<p><i>I can enjoy a good book or radio or television program:</i></p> <p>0 - Often 1 - Sometimes 2 - Not often 3 - Very seldom</p>

D = ___

A = ___

Impact of Weight on Quality of Life Questionnaire—Lite Version (IWQOL-Lite)

Please answer the following statements by circling the number that best applies to you in the past week. Be as open as possible. There are no right or wrong answers.

<u>Physical Function</u>		ALWAYS TRUE	USUALLY TRUE	SOMETIMES TRUE	RARELY TRUE	NEVER TRUE
1.	Because of my weight I have trouble picking up objects.	5	4	3	2	1
2.	Because of my weight I have trouble tying my shoes.	5	4	3	2	1
3.	Because of my weight I have difficulty getting up from chairs.	5	4	3	2	1
4.	Because of my weight I have trouble using stairs.	5	4	3	2	1
5.	Because of my weight I have difficulty putting on or taking off my clothing.	5	4	3	2	1
6.	Because of my weight I have trouble with mobility.	5	4	3	2	1
7.	Because of my weight I have trouble crossing my legs.	5	4	3	2	1
8.	I feel short of breath with only mild exertion.	5	4	3	2	1
9.	I am troubled by painful or stiff joints.	5	4	3	2	1
10.	My ankles and lower legs are swollen at the end of the day.	5	4	3	2	1
11.	I am worried about my health.	5	4	3	2	1
<u>Self-esteem</u>		ALWAYS TRUE	USUALLY TRUE	SOMETIMES TRUE	RARELY TRUE	NEVER TRUE
1.	Because of my weight I am self-conscious.	5	4	3	2	1
2.	Because of my weight my self-esteem is not what it could be.	5	4	3	2	1
3.	Because of my weight I feel unsure of myself.	5	4	3	2	1
4.	Because of my weight I don't like myself.	5	4	3	2	1
5.	Because of my weight I am afraid of being rejected.	5	4	3	2	1
6.	Because of my weight I avoid looking in mirrors or seeing myself in photographs.	5	4	3	2	1
7.	Because of my weight I am embarrassed to be seen in public places.	5	4	3	2	1

Sexual Life		ALWAYS TRUE	USUALLY TRUE	SOMETIMES TRUE	RARELY TRUE	NEVER TRUE
1.	Because of my weight I do not enjoy sexual activity.	5	4	3	2	1
2.	Because of my weight I have little or no sexual desire.	5	4	3	2	1
3.	Because of my weight I have difficulty with sexual performance.	5	4	3	2	1
4.	Because of my weight I avoid sexual encounters whenever possible.	5	4	3	2	1

Public Distress		ALWAYS TRUE	USUALLY TRUE	SOMETIMES TRUE	RARELY TRUE	NEVER TRUE
1.	Because of my weight I experience ridicule, teasing, or unwanted attention.	5	4	3	2	1
2.	Because of my weight I worry about fitting into seats in public places (e.g. theaters, restaurants, cars, or airplanes).	5	4	3	2	1
3.	Because of my weight I worry about fitting through aisles or turnstiles.	5	4	3	2	1
4.	Because of my weight I worry about finding chairs that are strong enough to hold my weight.	5	4	3	2	1
5.	Because of my weight I experience discrimination by others.	5	4	3	2	1

Work (Note: For homemakers and retirees, answer with respect to your daily activities.)		ALWAYS TRUE	USUALLY TRUE	SOMETIMES TRUE	RARELY TRUE	NEVER TRUE
1.	Because of my weight I have trouble getting things accomplished or meeting my responsibilities.	5	4	3	2	1
2.	Because of my weight I am less productive than I could be.	5	4	3	2	1
3.	Because of my weight I don't receive appropriate raises, promotions or recognition at work.	5	4	3	2	1
4.	Because of my weight I am afraid to go on job interviews.	5	4	3	2	1

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IWQOL-Lite – English (US).