The GW Medical Faculty Associates

Initials _____

MFA Weight Management Practice
Initial Consultation Survey

Name: _____ **Date of Birth (mm/dd/year)**: _____

I. Weight History

1. What is the main reason you want to lose weight?

   _____

   _____

   _____

2. How much would you like to weigh (desired weight)? _____

3. How long do you think it would take for you to reach your desired weight?

   _____

4. Have you ever been part of a weight loss program? ____Yes _____ No

   If yes please complete table below:

Name of program	Amount of weight loss	Length of time you kept weight off	Why did you stop the program?

Please answer true or false for the following statements:

I have binge eaten at least once a week for the past 3 months. _____

I eat a larger amount of food than most people would eat within 2 hours. _____

I feel like I do not have control when I eat. _____

I eat until I am uncomfortably full. _____

I eat large amounts of food when I am not physically hungry. _____

I eat much more rapidly than normal. _____

I eat alone out of embarrassment over how much I eat. _____

I feel disgusted, depressed, ashamed, or guilty after I overeat. _____

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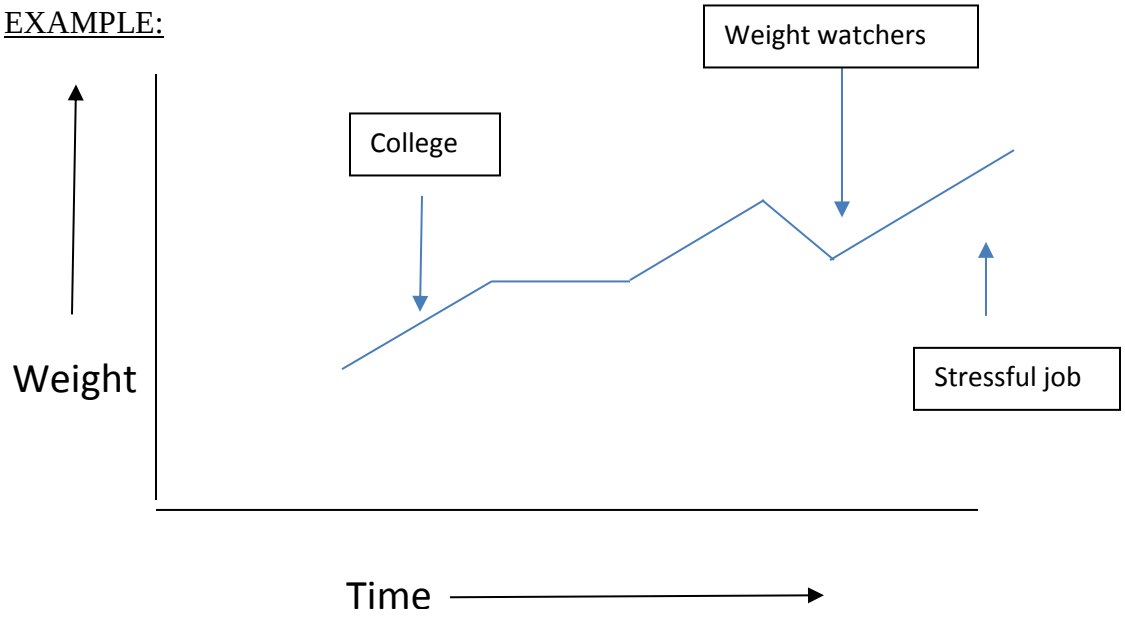
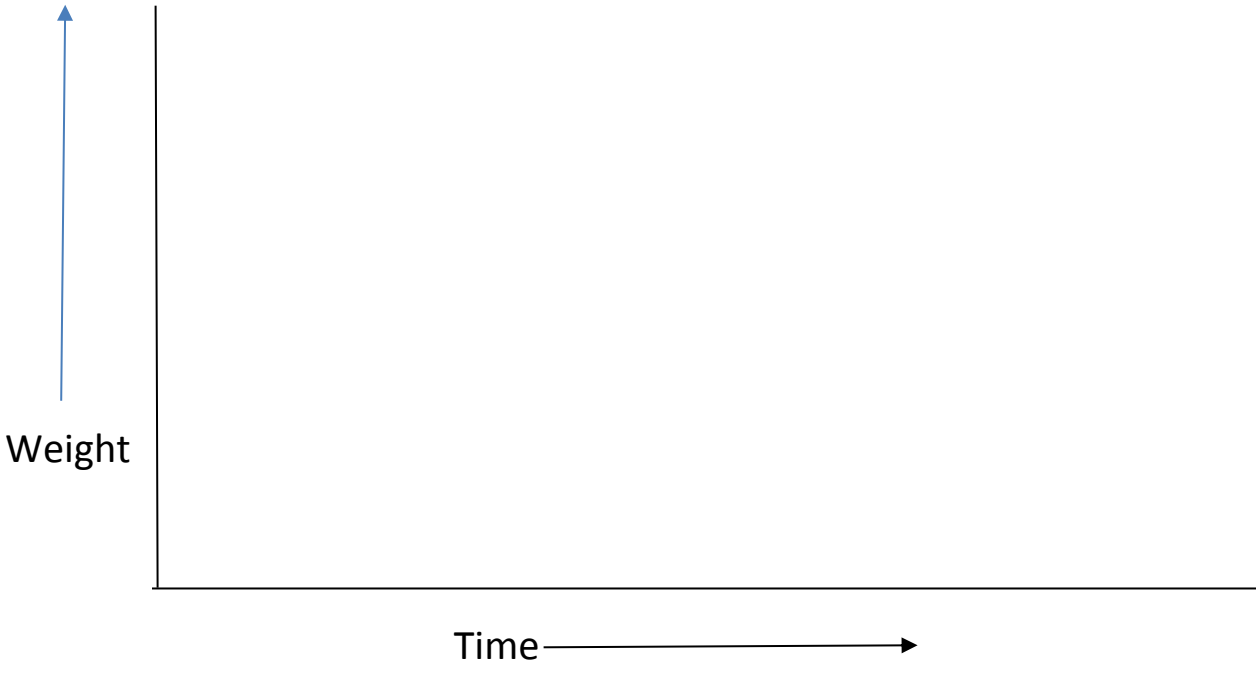
Weight History Graph

Most people can relate changes in their weight to different life events. The following graph illustrates an example of how people have gained weight.

EXAMPLE:



Please draw a graph of your weight gain and loss over time. Mark life events and diet attempts that have contributed to your current weight:



II. EATING PATTERNS

1. **Do you follow a special diet?** _____No _____Low Sodium _____Diabetic _____Vegetarian _____ Gluten free _____Other (Please specify_____)

2. **Over the past week (7 days), how many meals did you…**

…skip? _____

…eat with your family? _____

…eat in front of the TV or computer? _____

…eat at home? _____

…cook at home? _____

…eat fast food? _____

…eat at a restaurant that is not fast food? _____

3. **When do you snack?** _____Never _____Morning _____Afternoon _____Evening _____Late night _____Throughout the day

4. What are your favorite snack foods?

_____

_____

5. How often do you go to the grocery store? ____more than once a week _____once a week ___a few times a month ___once month ____less than once a month

6. Please indicate how many servings of each item you have per day and per week:

Food/Beverage/ Misc	Per Day	Per Week	Food/Beverage/ Misc	Per Day	Per Week
Cigarettes/cigars			Red Meat (3 oz)		
Coffee			Poultry (i.e. chicken or turkey) (3 oz)		
Alcoholic Beverage			Fish (3 oz)		
Dairy Products			Vegetables (1 cup)		
Sweetened Beverages (i.e. tea, soda, etc) (8 oz)			Legumes/Beans (i.e. peas, beans, lentils) (1 cup)		
Juice (8 oz)			Sweets/Desserts (i.e. 1 medium cupcake)		
Diet beverages (8 oz)			Fruits (1 cup)		
Water (8 oz)			Other:		

7. Do you have a scale at home? ____ Yes ___No

8. How many days out of the last month have you weighed yourself? _____

9. Do you have a pedometer or other physical activity tracking device? ___Yes ___No

10. Do you have a smart phone? ___ Yes ___No

11. **Eating Challenges—How often would you say you overeat when you are…**

	Always	**Usually**	**Not usually**	**Never**
…in a sad or negative mood?				
…tired?				
…happy or in a positive mood?				
…really busy or stressed?				
…at a party?				

12. Which describes the food situation in your household over the last month?

___Enough of the kinds of food we want to eat
___Enough but not always the kinds of food we want to eat
___Sometimes not enough to eat
___Often not enough to eat

13. Are you or anyone in your household currently receiving any of the following food assistance programs:

_____ Food stamps
_____ Senior nutrition programs (i.e. Meals on wheels)
_____ Free or reduced school lunch or breakfast
_____ Food pantries/coup kitchens
_____ Meals in childcare programs or head start
_____ WIC

Physical Activity

1. Do you have any physical injuries or pains that prevent you from exercising?
   ___ Yes ___ No

   a. If Yes, please describe the injury or pain:

   _____

b. Do you exercise regularly?___ Yes ___No

Type of Exercise	Number of days per week	Minutes per day

c. How much time do you spend sitting or reclining on a typical day?
_____hours _____minutes

Perceived stress scale

The questions in this scale ask you about your feelings and thoughts during the last month.

In the last month, how often have you:	Never	Almost never	Sometimes	Fairly often	Very often
…been upset because of something that happened unexpectedly?					
…felt that you were unable to control the important things in your life					
…felt nervous and "stressed"?					
…felt confident about you ability to handle your personal problems?					
…felt that things were going your way?					
…found that you could not cope with all the things that you had to do?					
…been able to control irritations in your life?					
…felt that you were on top of things?					
…been angered because of things that happened that were outside of your control?					
…felt difficulties were piling up so high that you could not overcome them?					

Social Network Questions

1. Is there someone that helps or encourages you to eat healthy foods and/or engage in exercise? ____Yes ___No

If yes:

a) Who is helpful _____ (i.e. sister, child, friend)

b) How are they helpful?

_____

_____

2. Is there someone that makes healthy eating or exercising more difficult for you?
____Yes _____No

If yes, please list how people are not helpful:

_____

_____

3. How many children live in your household? _____

Epworth Sleep Scale

How likely are you to doze off or fall asleep in the following situations? For each situation, indicate whether or not you would have:

- No chance of dozing = 0
- Slight chance of dozing = 1
- Moderate chance of dozing = 2
- High chance of dozing = 3

Situation	**Chance of dozing (options 0 to 3)**
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g. a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

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PHQ-9 Scale

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling asleep, staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling be about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
7. Trouble concentrating on things such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
9. Thinking that you would be better off dead or that you want to hurt yourself in some way				