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**NEW PATIENT MEDICAL HISTORY FORM**

Name: (First)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Last) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MI)\_\_\_\_

Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ Date of Visit: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Phone: (Home/Cell)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M / F

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How does your weight is affect your life and health? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Weight History**

When did you first notice that you were gaining weight?

🞏 Childhood 🞏 Teens 🞏 Adulthood 🞏 Pregnancy 🞏 Menopause

Did you ever gain more than 20 pounds in less than 3 months? Y / N If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much did you weigh: one year ago? \_\_\_\_\_ Five years ago? \_\_\_\_\_ 10 years ago? \_\_\_\_\_

Life events associated with weight gain (check all that apply):

🞏 Marriage 🞏 Divorce 🞏 Pregnancy 🞏 Abuse 🞏 Illness   
🞏 Travel 🞏 Injury 🞏 Nightshift work 🞏 Job change 🞏 Quitting smoking 🞏 Alcohol 🞏 Drugs

🞏 Medication (please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**Nutritional History**

How many meals do you have per day and at what time?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many snacks do you take per day/when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you eat most of your calories after supper? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wake up to eat? If so how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any food intolerances/restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food triggers (check all that apply):

🞏 Stress 🞏 Boredom 🞏 Anger 🞏 Insomnia 🞏 Seeking reward   
🞏 Parties 🞏 Eating out 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food cravings:

🞏 Sugar 🞏 Chocolate 🞏 Starches 🞏 Salty 🞏 Fast food  
🞏 High fat 🞏 Large portions

Favorite foods: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many portion per day of the following

Juice \_\_\_\_\_\_ Pop\_\_\_\_\_\_ Diet pop\_\_\_\_\_ Milk \_\_\_\_\_\_ (\_\_%) Coffee \_\_\_\_\_ Cream \_\_\_\_\_\_ (%\_\_)

Tea \_\_\_\_\_\_\_ Wine \_\_\_\_\_\_ Beer \_\_\_\_\_\_\_\_. Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many portions per week of the following

Pasta \_\_\_\_\_\_ Rice\_\_\_\_\_\_ Potatoes \_\_\_\_\_\_ Bread \_\_\_\_\_\_\_\_ Cheese \_\_\_\_\_\_\_ Red Meat \_\_\_\_\_\_

Poultry \_\_\_\_\_ Fish \_\_\_\_\_\_ Legumes \_\_\_\_\_\_

Fast food \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pastries and desserts\_\_\_\_\_\_\_\_\_

What do you eat most often?

Breakfast\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lunch \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supper \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many days per week do you go to out for meals/take out?

Breakfast \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lunch\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Supper \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous weight-loss programs (check all that apply):

🞏 Weight Watchers 🞏 Nutrisystem 🞏 Jenny Craig 🞏 LA Weight Loss 🞏 Atkins

🞏 South Beach 🞏 Zone diet 🞏 Medifast 🞏 Dash diet 🞏 Paleo diet

🞏 Meal replacements 🞏 Mediterranean diet 🞏 Ornish diet 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was your maximum weight loss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your greatest challenges with dieting? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your desired weight? \_\_\_\_\_\_\_\_\_\_\_\_\_. Which size clothing would you like to wear? \_\_\_\_\_\_\_\_\_\_\_

Do you have good support for weight loss at home ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever taken medication to lose weight? (check all that apply):

🞏 Contrave 🞏 Topamax 🞏 Saxenda 🞏 Meformin

🞏 Bupropion (Wellbutrin) 🞏 Xenical

Other (including supplements): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What worked? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What didn’t work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why or why not? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Exercise type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration: \_\_\_\_\_ hours \_\_\_\_\_ minutes Number of times per week: \_\_\_\_\_

Does anything limit you from exercising? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours do you sleep per night? \_\_\_\_\_\_\_\_\_\_ Do you feel rested in the morning? \_\_\_\_\_\_\_\_\_\_

Do you snore? \_\_\_\_\_\_\_\_\_ Heache in the morning? \_\_\_\_\_\_\_\_\_\_ Stop breathing during the night?\_\_\_\_\_\_

Past medical history (check all that apply):

🞏 Heart attack 🞏 Angina 🞏 Gallbladder stones 🞏 Sleep apnea

🞏 High blood pressure 🞏 Stroke 🞏 Indigestion/reflux 🞏 Thyroid

🞏 High cholesterol 🞏 Diabetes 🞏 Celiac disease 🞏 Anxiety

🞏 High triglycerides 🞏 Gout 🞏 Pancreatitis 🞏 Depression

🞏 Infertility 🞏 Arthritis 🞏 Polycystic Ovarian Syndrome 🞏 Bipolar  
🞏 Glaucoma 🞏 Cancer (type/s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been diagnosed with an eating disorder? Y / N If yes, which one? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past surgical history (check all that apply):

🞏 Gastric bypass 🞏 Gastric banding 🞏 Gastric sleeve 🞏 Gallbladder 🞏 Heart bypass   
🞏 Hysterectomy 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications (list all current medications, including over-the-counter medications, supplements, and herbs):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: (Medications)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Food)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy that you use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a private drug plan? If so which company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have access to the internet ?\_\_\_\_\_\_\_\_\_\_\_\_\_

Can we communicate with you through email, if so please provide email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

Smoking: 🞏 Never 🞏 Current smoker (\_\_\_\_\_ packs/day) 🞏 Past smoker (quit \_\_\_\_\_ years ago)

Alcohol: 🞏 Never 🞏 Occasional 🞏 Regularly (\_\_\_\_\_ drinks per day)

Prior treatment for alcoholism? Y / N

Drugs: 🞏 Never 🞏 Current 🞏 Past 🞏 Type of drugs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marijuana: 🞏 Never 🞏 Current user (\_\_\_\_\_ times/day)

Please describe your relationship status?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who lives with you ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Level of education? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your employment status? \_\_\_\_\_\_\_\_\_\_\_ What type of work do you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours do you work per week? \_\_\_\_\_\_\_\_\_\_. Do you work any shift work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Activity

🞏 None\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Mild activity such as daily chores, garden work, casual walks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Moderately active: Walk, run or other for 30 min 5x per week \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Very active, exercises regularly \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

Obesity (check all that apply): 🞏 Mother 🞏 Father 🞏 Sister 🞏 Brother

🞏 Daughter 🞏 Son

Diabetes (check all that apply): 🞏 Mother 🞏 Father 🞏 Sister 🞏 Brother

🞏 Daughter 🞏 Son

Other (check all that apply): 🞏 High blood pressure 🞏 Heart disease 🞏 High cholesterol

🞏 High triglycerides 🞏 Stroke 🞏 Thyroid problems 🞏 Anxiety 🞏 Depression

🞏 Bipolar disorder 🞏 Alcoholism 🞏 Cancer (type/s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gynecologic History**

Age periods started? \_\_\_\_\_ Age periods ended \_\_\_\_\_

Periods are: Regular / Irregular Heavy / Normal / Light

Number of pregnancies: \_\_\_\_\_ Number of children: \_\_\_\_\_

Age of first pregnancy: \_\_\_\_\_ Age of last pregnancy: \_\_\_\_\_

**System Review**

(Check all that apply)

🞏 Recent weight loss more than 10 pounds

🞏 Recent weight gain more than 10 pounds

🞏 Acne 🞏 Skin rash 🞏 Cough

🞏 Snoring 🞏 Shortness of breath 🞏 Chest pain

🞏 Difficulty breathing when flat 🞏 Fainting/Blacking out 🞏 Palpitations

🞏 Swelling ankles/extremities 🞏 Abdominal pain 🞏 Bloating

🞏 Constipation 🞏 Diarrhea 🞏 Food intolerance

🞏 Dysphagia/difficulty swallowing 🞏 Indigestion 🞏 Nausea/vomiting

🞏 Increased appetite 🞏 Decreased appetite 🞏 Heartburn

🞏 Gas and bloating 🞏 Urinary frequency/urgency 🞏 Slow urine flow

🞏 Nighttime urination 🞏 Blood in stools 🞏 Back pain (upper)

🞏 Back pain (lower) 🞏 Joint pain 🞏 Muscle aches/pain

🞏 Dizziness 🞏 Headaches 🞏 Seizures

🞏 Weakness/low energy 🞏 Anxiety 🞏 Depression

🞏 Insomnia 🞏 Memory loss 🞏 Inability to concentrate

🞏 Mood changes 🞏 Nervousness 🞏 Loss of interest

🞏 Cold intolerance 🞏 Excessive sweating 🞏 Hair changes

🞏 Heat intolerance 🞏 Blood clots 🞏 Fatigue/tiredness

**(Women only)**

🞏 Absence of periods 🞏 Hot flashes 🞏 Change in bladder habits

🞏 Abnormal/excessive menstruation 🞏 Facial hair

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Impulsive Eating**

1. During the last 3 months , did you have any episodes of excessive overeating (i.e. eating significantly more than what most people would eat in similar time)

🞏 Yes 🞏 No

If you said no you can stop here

1. Do you feel distressed about your episodes of excess overeating?

🞏 Yes 🞏 No

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Within the past 3 months** | **Never or Rarely** | **Sometimes** | **Often** | **Always** |
| **During your episode of excessive overeating**, how often did you feel like you had no control over your eating? (e.g not being able to stop eating, feel compelled to eat, or going back and further for more food) |  |  |  |  |
| **During your episode of excessive overeating,** how often did you continue eating even though you were not hungry? |  |  |  |  |
| **During your episode of excessive overeating** how often were you embarrassed by how much you ate? |  |  |  |  |
| **During your episode of excessive overeating** how often did you feel disgusted with yourself or guilty afterwards? |  |  |  |  |
| **During the last 3 months,** how often did you make yourself vomit as a mean to control your weight or shape? |  |  |  |  |

**Readiness for Change**

1. Life is fairly calm right now and I feel I’m ready to make a change about diet and lifestyle.

🞏 Yes 🞏 No

1. I believe I can change my eating, physical activity and behavioral habits

🞏 Yes. 🞏 No

1. Family, friends or both will support my lifestyle change effort

🞏 Yes 🞏 No

1. How confident do you feel that you can make a healthy lifestyle change?

🞏 Highly confident 🞏 Moderately confident 🞏 Slightly confident 🞏 Not confident at all

1. How motivated do you feel to make a healthy change in lifestyle?

🞏 Highly motivated 🞏 Moderately motivated 🞏 Slightly motivated. 🞏 Not motivated at all