Johns Hopkins Weight Management Center
Client Data Base

The information in this questionnaire will be reviewed by members of our clinical staff (physicians, dietitians, psychologists, exercise physiologists). Please be assured that all information that you provide will be regarded as confidential and will only be available to the professionals on your treatment team.

Please allow about 1 - 1-1/2 hours to complete the questionnaire. It is very important that everything is completed PRIOR to arriving for your first assessment. An incomplete application is likely to delay your appointment and ultimately, your treatment with us.

Full Name ____

Address ____

City _______________________________ State __________ Zip ___________

Phone (Home) ______________________ (Work) ___________________________

Date of Birth ________________________ Age _______ Sex ____ Race _______

Today's Date _______________________ Social Security Number _____________

Email Address____

Height _______Weight ________ Weight 1 year ago________

Lowest adult weight ______ What age? _______ How long? ________

Lowest adult weight maintained for 1 year _______ What age? _______

What is your personal goal weight at this time? ________ lbs.

Family History of Overweight (use back of page if needed):

Relative	**Age (or age at death)**	**Living (Y/N)**	**Degree of Overweight**			
			None	Slight (5-15 lbs)	Moderate (16-49 lbs)	Very (50+ lbs)
Father						
Mother						
Brother – oldest						
2nd oldest						
3rd oldest						
Sister – oldest						
2nd oldest						
3rd oldest						
Father's mother						
Father's father						
Mother's mother						
Mother's father						
Spouse/ partner						

For each time period, please record your maximum weight. If you cannot remember, make your best guess and mark “G.” ***Please note any events related to your weight during this period (i.e., in college, pregnant, end of relationship).***

Age	**Maximum Weight**	**Events Related to Weight Gain**
5-10		
11-15		
16-20		
21-25		
26-30		
31-35		
36-40		
41-50		
51-60		
60+		

Please record your major diets which resulted in a weight loss of 10 lbs. or more.

DIET	**AGE**	**WEIGHT AT START OF DIET**	**POUNDS LOST**	**COMMENTS**
1				
2				
3				
4				
5				
6				

How many times have you intentionally lost 20 lbs. or more and then gained it back?

Never ____ Once or twice ____ 3-4 times ____ 5 times or more ____

If you have been pregnant, please tell us about weight gain you experienced (use back of page if needed).

Age	Weight at start of pregnancy	Pounds gained during pregnancy	Lowest weight in year post-delivery

Check if you (or any family member) have or have had any of the following. Please explain any “yes” answers on the back of this sheet.

Condition	You	Relative (List Who)	Condition	You	Relative (List Who)
High Blood Pressure			Gallbladder disease		
Heart Disease			Liver disease		
Yellowing			Chest pain		
Thyroid Disease			Irregular heartbeat		
Kidney Disease			Alcoholism or drug abuse		
Shortness of Breath			Arthritis		
Stroke			Cancer		
Swelling of feet			Anemia		
Frequent headaches			Low back pain		
Seizures or epilepsy			Gout		
Psychological difficulties			Ulcers		
Psychiatric conditions			Constipation		
Depression			Chronic diarrhea		
Anxiety or panic attacks			Heartburn		
Hemorrhoids			Gas/ bloating		
Asthma			Chronic cough		
Phlebitis			Allergies		
Fainting/ lightheaded			Dizziness		
Diabetes			Frequent nausea		
Loss of muscle strength			Numbness in hands/ feet		
High cholesterol			Sleep difficulties		
Other					

Past Hospitalizations (include psychiatric as well as operations):

Year	Reason

Current Medications: (list all, including name, frequency, and dose; include hormones and birth control pills). ____

____

Please list any medication allergies: ______________________________________

Current Illnesses: ____

____

____

1) During the past 6 months, did you often eat within any two hour period what most people would regard as an unusually large amount of food? Yes _____ No _____

Complete questions a through h only if you answered yes to the previous question.

a. 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 _____

b. During the past 6 months, how often have you eaten this way (large amounts of food along with the feeling that your eating was out of control)?

Less than 1 day/wk ___1 day/wk ___ 2-3 days/wk ___4-5 days/wk ___ 6-7 days/wk _____

c. Did you experience any of the following during these occasions?

	Y	N		Y	N
Eating more rapidly than usual			Eating alone because of embarrassment about amount of food eaten		
Eating until uncomfortably full			Feeling disgusted, depressed or guilty after overeating		
Eating when not physically hungry					

d. What time of day did this type of eating occur?

Morning (8 am to noon) _____ Early afternoon (noon to 4 pm) _____
Late afternoon (4-7 pm) _____ Evening (7-10 pm) _____ Night (after 10 pm) _____

e. Approximately how long did the episode last (from the time you started eating to when you stopped and didn't eat again for at least 2 hours)? _______ hours _______minutes

f. At the time the episode started, how long had it been since you had previously finished eating a meal or a snack? __________ hours __________minutes

g. Please list everything you might have eaten or drank during the episode. Include brand names where possible, and your best estimate of amounts. Example: 7 ounces of Lays cheddar cheese potato chips; 2 cups of Lucerne chocolate ice cream with 3 tablespoons of hot fudge; 1 16-ounce bottle of Coca-cola; 1 ½ sandwich with ham, cheese, lettuce and tomato, mayonnaise and mustard.

____

____

____

h. How old were you when you first had times when you ate large amounts of food and felt that your eating was out of control? (If not sure, give best guess) _____years

In general, during the past 6 months, how important has your weight or shape been in how you feel about yourself as a person (as compared to other aspects of your life, such as how you do at work, as a parent, or how you get along with other people)?

	Y	N
Weight and shape were not very important		
Weight and shape played a part in how I felt about myself		
Weight and shape were among the main things that affected how I felt about myself		
Weight and shape were the most important factors in how I felt about myself		

During the past 6 months, how upset were you by overeating (eating more than you think is best for you)?

Not at all _____ Slightly ______ Moderately _____ Greatly _____ Extremely _____

Have you attempted any of the following behaviors in order to prevent gaining weight?

			Number of times/wk				
	Y	N	<1	1	2-3	4-5	6-7
Taking more than twice the recommended dose of diet pills							
Taking more than twice the recommended dose of laxatives							
Taking more than twice the recommended dose of diuretics							
Vomiting after eating							
Abstaining from food for more than 24 hours							
Exercising more than an hour							

Do you smoke cigarettes? Yes _____ No _____ If yes, # per day _____ # of years _____

Do you drink alcohol? Yes _____ No _____

If yes, type and amount of alcohol per week ____

Do you gamble? Yes ___ No ___ If so, how often?____________________________________

Does the amount of shopping you do create a problem for you (financial, personal, etc.)? ______

Do you have any compulsive behaviors? ____

Have you every participated in counseling or psychotherapy? Yes _____ No _____

If yes, type: Individual _______ Family ________ Couples ________ Substance abuse _________

Please describe when, with whom, and for what reason: _________________________________

____

Have you ever been the victim of abuse (physical, emotional, or sexual)? Yes _____ No _____

Marital or Relationship Status ________ Satisfaction with relationship right now ________________

Number of children and ages ____

Highest grade/college year completed ____

Occupation ______________________ What hours do you usually work? ___________________

How long have you worked there? _________yrs. Is your job satisfying?____________________

Has your weight caused you problems at work (please explain) ___________________________

____

Has your weight caused you problems at home (please explain) ______________________________

____

What are your hobbies and how do you spend your free time? ________________________________

____

Describe a typical weekend:

____

Is your family supportive of your weight loss efforts? _______ If yes, how?____________________

____

Is anyone likely to sabotage your efforts? ________________ If yes, how? ____________________

Have any of the following contributed to your weight problems?

	Y	N		Y	N
Stress			Sight and smell of food		
Anger/Frustration			Eating in restaurants		
Boredom			Poor planning		
Happiness			Second helpings		
Food as reward			Frequent snacking		
Being with others (co-workers, celebrations)			Holidays		
Genetic history			Sedentary lifestyle		

What does your hunger feel like? ____

How many times a day do you feel hungry? ____

What time of day are you most hungry? ____

How many times do you snack per day? ____

How many meals do you eat per day?____

How often do you eat breakfast? _______ What? ____

____

Do you eat before going to bed? _______ What? ____

____

What food habits would you like to change? ____

____

Who plans meals? ________________ Who cooks? ________________ Who shops? ____________

Which foods do you crave the most? ____

____

Do you eat while watching TV? _____ What do you eat? _________________________________

____

Time spent watching TV? _____hrs/d Time of day ______Ounces of caffeinated beverages/d_____

How often do you eat at:	**2-3 times/d**	**1 time/d**	**2-3 times/wk**	**1 time/wk**	**2-3 times/ mo**
Fast food restaurants					
Vending machines					
Cafeterias					
Hot dog/ food stands					
Full service restaurants					
Other _______________________					

Please indicate if you are currently experiencing stress in your life related to the following events:

	Y	**N**		**Y**	**N**
Work or possible job change			Children (birth, parenting issues, etc)		
Relationships (marriage, divorce, end of relationship			Financial difficulties		
Beginning/ending college			Death of friend or relative		
Moving			Other_____________________________		

Are you planning any major life changes in the next year? Yes _____ No _____

If yes, what? ____

What is the most significant source of stress at this time? ___________________________________

What are you doing about it? ____

____

What is one thing in your life you would like to accomplish/complete and why? (other than to lose weight)? ____

Think back on other weight loss attempts. How are you most likely to sabotage your efforts, both short-term and long-term?

____

Is there any additional information that would be helpful to us to know when developing your individualized weight management plan?

____

____

What are your current activities? (type, frequency, duration, length of consistency, level of enjoyment): ______________________________

What activities have you done in the past? (type, frequency, duration, length of consistency, level of enjoyment, reason for stopping): ______________________________

____

Days per week you are willing to devote to exercise ______________________________

Time of day you intend to exercise ______________________________

Amount of time available for this session ______________________________

Would you rather do all of your exercise in one session or split it up throughout the day?

____

Would you rather exercise solo, with a partner, in a group setting or with a trainer?

____

Would you rather exercise at home, at a health club, at work or outside? ______________________________

____

What do you see getting in the way of your exercise time? ______________________________

____

Resources: (Please specify)

	Y	N		Y	N
Health club membership			Trails/parks near home		
Exercise videos			High schools/colleges near home		
Exercise equipment			Personal trainer		

Other exercise resources available not mentioned above?______________________________

____

What do you feel you are gaining from being physically active (besides losing weight)? ___________

____

What type of physical activity is fun or enjoyable to you? (hiking, shopping, playing with your kids, etc.) ______________________________

____

What was the last positive experience you had while being physically active? ___________________

____

What made this experience positive? ____

What are your personal exercise goals? ____

____

Does your work schedule vary week to week? Yes___No___

Is your typical work day mostly sedentary? Yes___No___

Is there opportunity to get up and move around at work? Yes___No___

If you had to estimate all the activity you do throughout the day, how many minutes of activity do you accumulate? ______ (Includes taking stairs, walking to and from your car, rooms, etc.)

Are the following available at your workplace?

Stairs _______ Hallways _______ Privacy _______ Safe neighborhood/ grounds _______

Fitness center _____ Other ____

Do you experience any muscle or joint pain? If so, please explain. ___________________________

____

Have you had any injuries/ surgeries that inhibit exercise? If so, please explain. ________________

____

Are you physically limited in any way? ____

Interests: (Please circle all that are interesting to you)

Yoga	Dance	Free weights	Tennis
Pilates	Step aerobics	Weight machines	Competitive sport
Outdoor walk/ jog	Aerobics	Resistance bands	Outdoor cycling
Treadmill walk/ jog	Video tapes	Calisthenics	Exercise ball
Elliptical	Group classes	Personal training	Hiking
Stationary bike	Seated exercise	Swim activities	Other _____________

PHYSICIAN INFORMATION

Primary care physician

Full Name:____

Address:____

Phone Number: ____

Additional care provider(s)

Full Name:____

Address:____

Phone Number: ____

Full Name:____

Address:____

Phone Number: ____

EMPLOYMENT INFORMATION

Occupation: ____

Employer: ____

Address: ____

Policy Number (for Hopkins employees only)_________________________

EMERGENCY CONTACT

Name: ____

Phone Number: _____________________Relationship:_____________________

PHARMACY USED FOR PRESCRIPTION MEDICATIONS

Name: ____

Address: ____

Phone Number: ____

Client Name____

Thank you for taking the time to provide this important information.