UT SOUTHWESTERN – LIQUID PROTEIN DIET PROGRAM APPLICATION

(PLEASE PRINT CLEARLY)

Mail Application To: UT Southwestern Medical Center at Dallas
5323 Harry Hines Blvd., MC8871
Dallas, TX 75390-8871
(214) 645-2900

Or Fax To: (214) 645-2915 or (214) 645-2902

Patient Name: ______________________________ Date: ___/____/____

AKA (Also Known As): ______________________________

Home Address: ______________________________
Street

____
City State Zip Code

Home Phone :(____) ____________ Cell Phone: (____) ____________

Email Address: ______________________________

Age: ____ DOB: ___/___/___ **Sex**: ❑Male ❑Female **Height**: ____Feet ___ Inches **Weight**: ____ Pounds

Marital Status (Check One):
❑ Single ❑ Married ❑ Widowed
❑ Separated ❑ Divorced ❑ Domestic Partner

Employment Information: ______________________________
Business Name

______________________________ (____)____________ (____)____________
Occupation Work Phone Work Fax (Optional)

Diet Regimen: (Check One Box)

❑ VLCD-LIQUID FAST ❑ LCD-1,000 TO 1,500 Calories ❑ Maintenance
❑ MVLCD-Liquid W/1 Meal ❑ Full Food Diet ❑ Undecided

PRIMARY CARE PHYSICIAN (PCP):

______________________________ (____)____________ (____)____________
Name Office Phone Office Fax

❑ PLEASE REFER ME TO A PCP PROVIDER AT UT SOUTHWESTERN MEDICAL CENTER

DAILY STRESS LEVEL
(Please Indicate on a Scale of 1 to 10 with an **X**)

RELAXED______________________________STRESSED
0 1 2 3 4 5 6 7 8 9 10

MEDICAL HISTORY INFORMATION

FAMILY HISTORY

❑ Cancer	❑ Gout	❑ Heart Disease	❑ Kidney Disease	❑ Obesity
❑ Diabetes	❑ Heart Attack	❑ High Blood Pressure	❑ Liver Disease	❑ Stroke

CURRENT SYMPTOMS

❑ Abdominal Pain	❑ Dizziness	❑ Increase Urination	❑ Menstrual Changes	❑ Sedation	❑ Use More Than 1 Pillow at Night
❑ Anxiety	❑ Drowsy	❑ Indigestion	❑ Muscle Cramps	❑ Shortness of Breath	❑ Frequent Urination During The Nights
❑ Chest Pain	❑ Dry Mouth	❑ Insomnia	❑ Palpitations	❑ Sleep Apnea	________________
❑ Constipation	❑ Fainting	❑ Irregular Heartbeat	❑ Rapid Heartbeat	❑ Spaciness	
❑ Depression	❑ Fatigue	❑ Irritability	❑ Rash	❑ Foot Swelling	
❑ Diarrhea	❑ Headaches	❑ Memory Loss	❑ Restlessness		

PSYCHIATRIC HISTORY

Presently under Psychiatric Care?	❑ YES ❑ NO
Currently taking Psychotropic Drugs?	❑ YES ❑ NO
Have Severe Depression requiring treatment?	❑ YES ❑ NO

PREGNANCY – FOR FEMALE PATIENTS ONLY

Currently trying to get Pregnant?	❑ YES ❑ NO
Currently Pregnant?	❑ YES ❑ NO
Currently Breastfeeding?	❑ YES ❑ NO

MEDICAL CONDITIONS OR DIAGNOSIS

❑ **None**	❑Chronic Fatigue Syndrome	❑ Elevated Cholesterol
❑ Abdominal Pain General	❑ Congestive Heart Failure	❑ Hypertension
❑ Abnormal Weight Gain	❑ Constipation	❑ Thyroid Problems
❑ Abnormal Weight Loss	❑ COPD (Chronic Obstructive Pulmonary Disease)	❑ Insomnia
❑ AIDS	❑ Cough	❑ Irritable Bowel Syndrome
❑ Allergies	❑ Depression	❑ Low Back Pain
❑ Anemia	❑ Diabetes Mellitus Type_______________	❑ Malnutrition, Moderate
❑ Anorexia	❑ Dizziness	❑ Migraine
❑ Arthritis	❑ Fatigue	❑ Nausea & Vomiting
❑ Asthma	❑ Generalized Pain	❑ Obesity
❑ Binge-Eating Disorder	❑ Glaucoma	❑ Seizure
❑ Bipolar Disorder	❑ Gout	❑ Shortness of Breath
❑ Breast Mass, Female	❑ Graves Disease	❑ Sleep Apnea
❑ Bulimia Nervosa	❑ Headache	❑ Syncope
❑ Cancer Type_____________________	❑ Hepatitis A	❑ Ulcer
	❑ Hepatitis B	❑ Urinary Problems
❑Cardiac Problems Type______________	❑ Hepatitis C	❑ Voice Hoarseness
		❑ Other: ___________________________

Explanation of any checked above: ____

____

____

SURGERIES/OPERATIONS (Most Recent)

1) ____ YEAR _________

2) ____ YEAR _________

3) ____ YEAR _________

4) ____ YEAR _________

5) ____ YEAR _________

6) ____ YEAR _________

PRESCRIPTION MEDICATION

❑ Not Taking Any Medications

If you are a current or recent patient of UT Southwestern Medical Center, complete the form with updated medications only. The EPIC system will list prior medicines in your medical records (based on given medicine information).

If you are a new patient to UT Southwestern Medical Center please list all medications, including over the counter medications, vitamins and supplements.

MEDICATION	DISCONTINUE DATE	SINGLE DOSE	DOSES /DAY	TOTAL DOSE	REASON FOR MEDICATION
Norvasc-**Example Only**	__/__/__	5 MG	2/Day	10 MG	High Blood Pressure-**Example Only**
Bayer Aspirin-**Example Only**	__/__/__	81 MG	1/Day	81 G	Frequent Headaches-**Example Only**
Vitamin C-**Example Only**	__/__/__	500 MG	3/Day	1500	Promote Healthy Heart-**Example Only**
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NUTRITION AND PHYSICAL ACTIVITY HISTORY

WEIGHT HISTORY

How long have you been at your current weight? _____________
What has been your maximum weight loss? _____________
How long did it take to achieve your maximum weight loss? _____ ____
What has been your heaviest adult weight? ___________ Year __________
How long has it been since you weighed your goal weight? ________
How long did you maintain your goal weight? _____________
What has been your lightest adult weight? ________ Year_________

DIETING HISTORY

❑ Current Dietary Regimen: ____

____

Previous Therapies Used For Weight Loss (Check all that apply)**:**

❑ Shots ❑ Pills ❑ Diets ❑ Individual Counseling ❑ Group Therapy
❑ Gastric Surgery ❑ Dietitian/Nutritionist ❑ Fasting Diet/Very Low Calorie Diet (VLCD) ❑ Modified (VLCD + Meal)

Which Diets have you followed in the past? (Check all that apply)

❑ Atkins	❑ Jenny Craig	❑ Overeaters Anonymous	❑ Sugar Busters	❑ Other _______________
❑ Calorie Counting	❑ Lindora	❑ RFO Program	❑ Vegetarian Diet	________________________
❑ Food Guide Pyramid	❑ Nutrasystem	❑ Slim Fast	❑ Weight Watchers	
❑ HMR	❑ OPTIFAST	❑ South Beach Diet	❑ Zone Diet	

NUTRITION PRACTICES

DEMOGRAPHICS List Country, State or Province Where You Lived AS A (AN):

Infant: ____
Adolescent: ____
Teenager: ____
Adult: ____

ETHNICITY (Check all that apply)

❑ Afghani	❑ Chinese	❑ French Polynesian	❑ Iraqi	❑Native American Indian	❑ Saudi Arabian
❑ African	❑ Columbian	❑ German	❑ Irish	❑ Nicaraguan	❑ Scottish
❑ African American	❑ Costa Rican	❑ Greek	❑ Israeli	❑ Norwegian	❑ Slovakian
❑ Argentinean	❑ Cuban	❑ Guatemalan	❑ Italian	❑Pacific Islander	❑ South African
❑ Australian	❑ Danish	❑ Guinea	❑ Jamaican	❑ Pakistani	❑ Spaniard
❑ Brazilian	❑ Dominican Republic	❑ Hispanic	❑ Japanese	❑ Palestinian	❑ Swedish
❑ British	❑ Egyptian	❑ Honduran	❑ Jordanian	❑ Panamanian	❑ Taiwanese
❑ Cambodian	❑ El Salvadoran	❑ Hungarian	❑ Korean	❑ Polish	❑ Turkish
❑ Canadian	❑ English	❑ India	❑ Lebanese	❑ Puerto Rican	❑ Ukrainian
❑ Chechen	❑ Eskimo	❑ Indonesian	❑ Mexican	❑ Romanian	❑ Vietnamese
❑ Chilean	❑ French	❑ Iranian	❑ Moroccan	❑ Russian	
❑Other:________					_________________

Does your Nationality and Culture influence your diet/eating habits? ❑ YES ❑ NO If yes, please explain: _______________________________

____

RELIGION

❑ NONE	❑ Christianity	❑ Islam	❑ Methodist	❑ Scientology
❑ Baptist	❑ Christian Science	❑ Jehovah Witness	❑ Mormon	❑ _____________________
❑ Buddhist	❑ Episcopalian	❑ Jewish	❑ Muslim	
❑ Catholic	❑ Hindu	❑ Lutheran	❑ Protestant	

Does your Religion influence your diet/eating habits? ❑ YES ❑ NO If yes, please explain: ____

____

FOOD CONTRAINDICATIONS – Food Allergies and Intolerances

List all **Food Allergies** (Nuts, Soy, Eggs, etc.): ____

____

List all **Food Intolerances** (Milk/Lactose Intolerance, etc.):____

____

List all **Foods You** avoid and why: ____

____

FLUID CONSUMPTION

How many ounces of water do you drink on a daily basis? ______________________________

Do you drink caffeinated beverages? ❑ YES ❑ NO If yes, which ones and how many per day? ______________________________

____

Do you drink alcoholic beverages? ❑ YES ❑ NO If yes, please list type, frequency and amount.______________________________

____

EATING PATTERNS

Do you skip meals on a regular basis? Please explain: ______________________________

Do you eat meals at home, out or both? Please explain: ______________________________

When are you most hungry and/or eat the most? (Check all that apply) ❑ Morning ❑ Afternoon ❑ Evening ❑ No Pattern

What foods do you usually consume at these times? ______________________________

What is your typical eating pattern like? (Indicate time of meals and snacks. Briefly describe what you eat at these meals.)

Breakfast	Mid-afternoon Snack
Mid-morning Snack	**Dinner**
Lunch	**Evening Snack**

Please check the foods you eat regularly and how many times a week you eat them.

DAIRY (X/WK = Times per week)

❑ Buttermilk ________X/WK	❑ Cottage Cheese-Reg. ________X/WK	❑ Milk 2% ________X/WK
❑ Cheese-Regular ________X/WK	❑ Cottage Cheese - Low/Red Fat ____X/WK	❑ Milk Non Fat/Skim ________X/WK
❑ Cheese-Low/Red Fat ________X/WK	❑ Cottage Cheese - Other________X/WK	❑ Yogurt Regular ________X/WK
❑ Cheese-Non Fat ________X/WK	❑ Milk Goat ________X/WK	❑ Yogurt Non Fat ________X/WK
❑ Cheese-Other ________X/WK	❑ Milk Whole ________X/WK	❑ Dairy Other ________X/WK

PROTEINS - Meats, Poultry, Fish, Dry Beans, Eggs & Nuts (X/WK = Times per week)

❑ Beef ______X/WK- Type__________	❑ Luncheon Meats ________X/WK	❑ Eggs-Whole ________X/WK
❑ Chicken Breast ________X/WK	❑ Pork ________X/WK	❑ Eggs-Whites Only ________X/WK
❑ Chicken Leg/Thigh ________X/WK	❑ Sashimi ________X/WK	❑ Eggs-Substitute ________X/WK
❑ Chicken w/Skin ________X/WK	❑ Sausage ________X/WK	❑ Dry Beans (Black, etc) ________X/WK
❑ Duck ________X/WK	❑ Shellfish ________X/WK	❑ Legumes (Lentils, etc) ________X/WK
❑ Fish ________X/WK	❑ Sushi ________X/WK	❑ Peanut Butter ________X/WK
❑ Ham ________X/WK	❑ Tuna ________X/WK	❑ Nut Butter-Other ________X/WK
❑ Hamburgers__________ ____X/WK	❑ Turkey Breast ________X/WK	❑ Nuts (Almonds, etc) ________X/WK
❑ Hot Dogs ________X/WK	❑ Turkey-Other ________X/WK	❑ Seeds (Pumpkin, etc) ________X/WK
❑ Lamb ________X/WK	❑ Venison (Deer) ________X/WK	❑ Other ________X/WK

BREADS, GRAINS & STARCHES (X/WK = Times per week)

❑ Bagel ________________X/WK
❑ Bread-White ___________X/WK
❑ Bread-Whole Wheat _____X/WK
❑ Cereal-Dry ____________X/WK
❑ Cereal-Cooked _________X/WK
❑ Crackers ______________X/WK
❑ Dinner Rolls ___________X/WK
❑ English Muffins ________X/WK
❑ Grains (Barley, etc) _________X/WK
❑ Hamburger Buns ___________X/WK
❑ Hot Dog Buns _____________X/WK
❑ Pasta/Noodles _____________X/WK
❑ Pita Bread ________________X/WK
❑ Popcorn __________________X/WK
❑ Potato-Baked ______________X/WK
❑ Potato-Mashed _____________X/WK
❑ Pretzels _______________X/WK
❑ Rice-Steamed __________X/WK
❑ Rice-Fried _____________X/WK
❑ Rice Cakes _____________X/WK
❑ Sweet Potato ____________X/WK
❑ Tortillas-Corn ___________X/WK
❑ Tortillas-Flour _________ _X/WK
❑ Yams __________________X/WK
❑ Other ____________ ______X/WK

VEGETABLES (X/WK = Times per week)

❑ Artichokes _____________X/WK
❑ Asparagus _____________X/WK
❑ Beets _________________X/WK
❑ Bell Peppers ____________X/WK
❑ Broccoli _______________X/WK
❑ Brussels Sprouts _________X/WK
❑ Cabbage _______________X/WK
❑ Carrots ________________X/WK
❑ Cauliflower ____________X/WK
❑ Celery ________________X/WK
❑ Corn ____________________X/WK
❑ Cucumber ________________X/WK
❑ Eggplant _________________X/WK
❑ Green Beans ______________X/WK
❑ Green Lettuce _____________X/WK
❑ Greens (Collards, etc) _______X/WK
❑ Jicama ___________________X/WK
❑ Mushrooms ________________X/WK
❑ Onions ___________________X/WK
❑ Peas _____________________X/WK
❑ Spinach _______________________X/WK
❑ Squash-Summer (Zucchini, etc _____X/WK
❑ Squash-Winter (Butternut, etc) _____X/WK
❑ Tomatoes _____________________X/WK
❑ Canned Vegetables ______________X/WK
❑ Dried Vegetables ________________X/WK
❑ Frozen Vegetables ______________X/WK
❑ Vegetable Juice ________________X/WK
❑ Vegetables-Other _______________ X/WK
❑ Vegetables-Other _______________ X/WK

FRUITS (X/WK = Times per week)

❑ Apples _________________X/WK
❑ Apricots ________________X/WK
❑ Avocado ________________X/WK
❑ Bananas ________________X/WK
❑ Berries) _________________X/WK
(Strawberry, Blueberry, Raspberry, etc)
❑ Cherries ________________X/WK
❑ Figs __________________X/WK
❑ Grapefruit ______________X/WK
❑ Grapes _________________X/WK
❑ Kiwi ______________________X/WK
❑ Mango________________ _______X/WK
❑ Melon (Cantaloupe, etc) _________X/WK
❑ Mixed Fruit _________________X/WK
❑ Nectarines __________________X/WK
❑ Olives _____________________X/WK
❑ Orange _____________________X/WK
❑ Papaya _____________________X/WK
❑ Peach ______________________X/WK
❑ Pear _______________________X/WK
❑ Pineapple ________________X/WK
❑ Plums______________ ____X/WK
❑ Pomegranates _____________X/WK
❑ Canned Fruit ______________X/WK
❑ Dried Fruit ________________X/WK
❑ Fruit Juice ________________X/WK
❑ Frozen Fruit _______________X/WK
❑ Fruits-Other ________________X/WK
❑ Fruits-Other ________________X/WK
❑ Fruits-Other ________________X/WK

VEGETARIAN ITEMS (X/WK = Times per week)

❑ Breakfast (Patties, etc) ________X/WK
❑ Burgers/Patties ______________X/WK
❑ Cultured Soy (Yogurt, etc) _____X/WK
❑ Meat Analog (Chicken, etc) _____X/WK
❑ Rice Beverage _______________X/WK
❑ Soy-Based Desserts ___________X/WK
❑ Soy Beverage (Milk, etc) _______X/WK
❑ Soy Cheese __________________X/WK
❑ Soy Crisps __________________X/WK
❑ Soy Dogs/Links _______________X/WK
❑ Soy Jerky ___________________X/WK
❑ Soy Nuts ____________________X/WK
❑ Textured Vegetable Protein ______X/WK
❑ Tofu ________________________X/WK
❑ Vegetarian Items-Other _________X/WK

BEVERAGES (X/WK = Times per week)

❑ Beer-Light _________________X/WK
❑ Beer-Regular _______________X/WK
❑ Blended Coffee Drinks ________X/WK
❑ Calorie Free Drinks ___________X/WK
❑ Champagne _________________X/WK
❑ Coffee _____________________X/WK
❑ Coffee/Tea w/Cream _________X/WK
❑ Coffee/Tea w/Sugar __________X/WK
❑ Diet Drinks (Crystal Light, etc) ______X/WK
❑ Diet Soda _______________________X/WK
❑ Fruit Smoothies ___________________X/WK
❑ Fruit Punch _______________________X/WK
❑ Hot Chocolate _____________________X/WK
❑ Iced Tea-Sweetened ______________X/WK
❑ Juice __________________________X/WK
❑ Milk Shakes ______________________X/WK
❑ Mixed Cocktails ____________X/WK
❑ Protein Shakes ______________X/WK
❑ Regular Soda _______________X/WK
❑ Shots _____________________X/WK
❑ Tea ______________________X/WK
❑ Wine-Red ___________________X/WK
❑ Wine-White _________________X/WK
❑ Other _______________ _______X/WK

HIGH CALORIE FOODS/SNACK ITEMS (X/WK = Times per week)

❑ Bacon ____________________X/WK
❑ Bagel w/Cream Cheese _______X/WK
❑ Biscotti __________________X/WK
❑ Burrito's _________________X/WK
❑ Cake _____________________X/WK
❑ Candy ____________________X/WK
❑ Candy Bars ________________X/WK
❑ Cheese & Crackers __________X/WK
❑ Chips-Potato ______________X/WK
❑ Chips-Tortilla ________________X/WK
❑ Chocolate ___________________X/WK
❑ Cookies ____________________X/WK
❑ French Fries __________________X/WK
❑ Fried Foods ___________________X/WK
❑ Frozen Yogurt _________________X/WK
❑ Ice Cream-Low Fat _____________X/WK
❑ Ice Cream-Regular _____________X/WK
❑ Lasagna _____________________X/WK
❑ Muffins/Scones ______________X/WK
❑ Nachos ____________________X/WK
❑ Pastries ____________________X/WK
❑ Pie ________________________X/WK
❑ Pizza ______________________X/WK
❑ Sub Sandwiches ______________X/WK
❑ Tacos ______________________X/WK
❑ Other _______________________X/WK

MISCELLANEOUS ITEMS (X/WK = Times per week)

❑ Barbeque Sauce ____________X/WK	❑ Mayonnaise ______________X/WK	❑ Steak Sauce ______________X/WK
❑ Butter ____________________X/WK	❑ Mustard _________________X/WK	❑ Sugar ___________________X/WK
❑ Cream Cheese ______________X/WK	❑ Oils ____________________X/WK	❑ Syrup ___________________X/WK
❑ Cream Sauces ______________X/WK	❑ Protein Bars ______________X/WK	❑ Tomato Based Sauces _________X/WK
❑ Guacamole ________________X/WK	❑ Salad Dressing-Creamy _______X/WK	❑ Whipped Cream ______________X/WK
❑ Jelly/Jam/Preserves _________X/WK	❑ Salad Dressing-Oil ___________X/WK	❑ Other ______________________X/WK
❑ Ketchup __________________X/WK	❑ Sour Cream _______________X/WK	❑ Other ______________________X/WK
❑ Margarine _________________X/WK	❑ Soy Sauce ________________X/WK	❑ Other ______________________X/WK

PHYSICAL ACTIVITY: (Please check all that apply)

❑ No Exercise ❑ Cardio Exercise _______ Days/Week Strength Training _______ Days/Week

PHYSICAL ACTIVITY & EXERCISES (Please check all that apply

AB Exercise	Curves	Golf	Personal Trainer	Stairs Up/Down	Surfing
Aerobics	Dancing	Hiking	Pilates	Stationary Bike	Tennis
Basketball	Dumb Bells	Housework	Pull Ups	Step Mill	Trampoline
Bicycling	Elliptical	Jogging	Push Ups	Stretching	Treadmill
Body Ball	Exercise Books	Jumping Rope	Rowing	Stretch Tube	Walking
Bow Flex Machine	Exercise Videos	Lawn Mowing	Skating	Swimming	Weight Machines
Calisthenics	Gardening	Medicine Ball	Stair Climb	Swim w/Weights	YOGA

Do you have any physical conditions that limit your physical activity? ❑ YES ❑ NO If yes, please explain.

____

____

DAILY OVERALL ACTIVITY LEVEL
(PLEASE INDICATE ON A SCALE OF 1 TO 10 WITH AND **X**)

SEDENTARY____________________MODERATE____________________VERY ACTIVE

0 1 2 3 4 5 6 7 8 9 10

GENERAL WELL BEING SCHEDULE

This section of the examination contains questions about how you feel and how things have been going with you during the last month. For each question check the box next to the answer which best applies.

1. How have you been feeling in general?
   ❑Excellent ❑ Very Good ❑ Mostly Good ❑ Up & Down ❑Low Spirits ❑ Very Low
2. Have you been bothered by nervousness or your “nerves”?
   ❑ Extremely ❑ Mostly ❑ Quite A Bit ❑ Sometimes ❑ A Little ❑ Not At All
3. Have you been in firm control of your behavior, thoughts, emotions or feelings?
   ❑ Definitely ❑ Mostly ❑ Generally ❑ Not Too Well ❑ No, I Am A Little Disturbed
   ❑ No, I Am Very Disturbed
4. Have you felt sad, discouraged, hopeless, or wondered if everything was worthwhile?
   ❑ Extremely ❑ Very Much ❑ Quite A Bit ❑ Sometimes ❑ A Little Bit ❑ Not At All
5. Have you been under or felt you were under any strain, stress or pressure?
   Quite a Bit ❑About Usual ❑A Little ❑Not at All ❑More Than I Can Stand ❑More Than Usual
6. How happy, satisfied or pleased have you been with your personal life?
   ❑Extremely ❑Very Happy ❑Fairly Happy ❑Pleased ❑Dissatisfied ❑Very Unhappy
7. Have you had any reason to wonder if you were losing control of yourself?
   ❑Not at All ❑A Little ❑Not Enough to be Concerned ❑A little Concern ❑Quite Concerned
   ❑Very Concerned
8. Have you been anxious, worried or upset?
   ❑Extremely ❑Very Much ❑Quite a Bit ❑Sometimes ❑A little Bit ❑Not at All
9. Have you been waking up fresh and rested?
   ❑Everyday ❑Mostly ❑Fairly Often ❑Not at All ❑Less Than Half the Time ❑Rarely

10. Have you been bothered by illness, bodily disorder, pains or fears about your health?
❑All The Time ❑Mostly ❑Quite A Bit ❑Sometimes ❑A little Bit ❑Not at All

11. Has your daily life been full of things that interested you?
❑Excellent ❑Very Good ❑Mostly Good ❑Up & Down ❑Low Spirits ❑Very Low

12. Have you felt down-hearted and blue?

❑All the Time ❑Mostly ❑Fairly Often ❑Sometimes ❑A little Bit ❑Not at All

13. Have you been feeling emotionally stable and sure of yourself?
❑All the Time ❑Mostly ❑Quite a Bit ❑Sometimes ❑A little Bit ❑Not at All

14. Have you felt tired, worn out, used up or exhausted?
❑All the Time ❑Mostly ❑Quite a Bit ❑Sometimes ❑A little Bit ❑Not at All

15. How concerned or worried about your health have you been?

NOT CONCERNED VERY CONCERNED
❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

16. How relaxed or tense have you been?

VERY RELAXED VERY TENSE
❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

17. How much energy, pep and vitality have you felt?

NO ENGERY VERY ENERGETIC
❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

18. How DEPRESSED or CHEERFUL have you been?

VERY DEPRESSED _ VERY CHEERFUL
❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

DIETING READINESS TEST

1. Compared to previous attempts, how motivated to lose weight are you now?
❑Not at all ❑Slightly ❑Somewhat ❑Quite ❑Extremely

2. How certain are you that you will stay committed to a program, until your goal is reached?
❑Not at all ❑Slightly ❑Somewhat ❑Quite ❑Extremely

3. Consider outside factors in your life. To what extent can you tolerate the effort of dieting?
❑Cannot ❑Somewhat ❑Uncertain ❑Well ❑Easily

4. Think about how much and how fast you want to lose weight. Figure 1-2 pounds per week. How realistic are your expectations?
❑Not at all ❑Bit Unrealistic ❑Moderately ❑Extremely ❑Bit Realistic

5. While dieting, do you fantasize about eating a lot of your favorite foods?
❑Always ❑Frequently ❑Occasionally ❑Rarely ❑Never

6. While dieting, do you feel deprived, angry, and or upset?
❑Always ❑Frequently ❑Occasionally ❑Rarely ❑ Never

7. When food comes up in conversation or readings do you feel like eating?
❑Not at all ❑Rarely ❑Occasionally ❑Frequently ❑Always

8. How often do you eat because of physical hunger?
❑Always ❑Frequently ❑Occasionally ❑Rarely ❑Never

9. Do you have trouble controlling your eating when foods you like are around the house?
❑Not at all ❑Rarely ❑Occasionally ❑Frequently ❑Always

If the following occurred while you were on a diet, would you be likely to eat more or less immediately after and the rest of the day?

10. Although you planned on skipping lunch, a friend invites you to go out for a mid-day meal.
❑Eat much less ❑Somewhat less ❑No Change ❑Somewhat more ❑Much more

11. You “Break” your diet by eating a fattening “Forbidden” food.

❑ Eat Much Less ❑Somewhat Less ❑ No Change ❑Somewhat More ❑Much More

12. You have been following the diet faithfully and decided to test yourself with a “Treat”.
❑Eat Much Less ❑Somewhat Less ❑ No Change ❑Somewhat More ❑Much More

13. Aside from Holidays, have you eaten a large amount quickly, and then felt it had been uncontrolled?
❑YES ❑NO

14. If yes to 13, how often have you engaged in this behavior in the last year?
❑Less Than Once a Month ❑Once a Month ❑Few Times a Month ❑Once a Week
❑Few Times a Week ❑Daily

15. Have you ever purged (used Laxatives, Diuretics, or Induced Vomiting) to control weight?
❑YES ❑NO

16. If yes to 15, how often have you engaged in this behavior in the last year?
❑Less than once a month ❑Once a Month ❑Few Times a Month ❑Once a week ❑ Few Times a Week
❑ Daily

17. Do you eat more than you would like to when you have negative feelings (Anxiety, Depression, or Anger)?
❑Not all ❑Rarely ❑Occasionally ❑Frequently ❑ Always

18. Do you have trouble controlling your eating when you have positive feelings (celebrating it)?
❑Not at all ❑Rarely ❑Frequently ❑Always ❑Occasionally

19. When you have unpleasant interactions with others or a bad workday, do you eat more?
❑Not at all ❑Rarely ❑Frequently ❑Always ❑Occasionally

20. How often do you exercise?
❑Not at all ❑Frequently ❑Rarely ❑Occasionally ❑Somewhat

21. How confident are you that you will exercise frequently?
❑Not at all ❑Slightly ❑Somewhat ❑Quite ❑Extremely

22. When you think about exercise, do you develop a Positive or Negative picture in your mind?
❑ Very Negative ❑ Little Negative ❑ Neutral ❑ Little Positive ❑ Very Positive

23. How certain are you that you can work regular exercise into your daily schedule?
❑Not at all ❑Slightly ❑Somewhat ❑Quite ❑Extremely