comprehensive
Women's Health
Primary Care For Women

CWH Weight Management Program Patient Questionnaire

- American Medical Association Weight Loss Questionnaire
- Lifestyle Pattern Questionnaire
  - Eating pattern
  - Exercise Habits
- Depression Screening
- Anxiety Screening
- In depth Questions

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Figure 4.1

Eating Pattern Questionnaire

Name _____ Date _____

Please answer the following questions and check the appropriate boxes that most closely describe your eating patterns.

1. Do you follow a special diet?
   ☐ No ☐ Diabetic ☐ Low sodium
   ☐ Low fat ☐ Kosher ☐ Vegetarian
   ☐ Other

   Give examples of what guidelines or diets, if any, you follow: _____

2. Which meals do you regularly eat?
   ☐ Breakfast ☐ Lunch ☐ Brunch ☐ Dinner

3. When do you snack?
   ☐ Morning ☐ Afternoon ☐ Evening
   ☐ Late night ☐ Throughout the day

   What are your favorite snack foods? _____

4. Do you eat out or order food in?
   ☐ Yes ☐ No

   How often?
   ☐ Daily ☐ Weekly ☐ Monthly ☐ Other

   What kind of restaurant(s)/eating facilities? _____

   What kinds of cuisine? _____

5. How is your food usually prepared? (check all that apply)
   ☐ Baked ☐ Broiled ☐ Boiled ☐ Fried
   ☐ Steamed ☐ Poached ☐ Other

6. How many times each day do you have the following food items?

   a. Starch (bread, bagel, roll, cereal, pasta, noodles, rice, potato)
      ☐ Never ☐ Less than 1 ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ 9-11

   b. Fruit
      ☐ Never ☐ Less than 1 ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ 9-11

   c. Vegetables
      ☐ Never ☐ Less than 1 ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ 9-11

   d. Dairy (milk, yogurt)
      ☐ Never ☐ Less than 1 ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ 9-11

   e. Meat, fish, poultry, eggs, cheese
      ☐ Never ☐ Less than 1 ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ 9-11

   f. Fat (butter, margarine, mayonnaise, oil, salad dressing, sour cream, cream cheese)
      ☐ Never ☐ Less than 1 ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ 9-11

   g. Sweets (candy, cake, regular soda, juice)
      ☐ Never ☐ Less than 1 ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ 9-11

7. What beverages do you drink daily and how much?
   ☐ Water ____ times or glasses per day (8 oz)
   ☐ Coffee ____ times or cups per day
   ☐ Tea ____ times or cups per day
   ☐ Soda ____ times or glasses per day (12 oz)
   ☐ Alcohol ____ times or glasses per day (12 oz)
   ☐ Other ____ times or glasses per day
   (Specify) _____

8. Would you like to change your eating habits?
   ☐ Yes ☐ No

   Which habits would you like to begin to change?

Adapted with permission from the Wellness Institute, Northwestern Memorial Hospital.

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Figure 3.3

Weight Loss Questionnaire

Name _____ Date _____

Please complete this questionnaire, which will help you and your physician develop the best management plan for you.

1. Is there a reason you are seeking treatment at this time?
   _____
2. What are your goals about weight control and management? _____
3. Your level of interest in losing weight is:
   Not interested 1 2 3 4 5 Very interested
4. Are you ready for lifestyle changes to be a part of your weight control program?
   Not ready 1 2 3 4 5 Very ready
5. How much support can your family provide?
   No support 1 2 3 4 5 Much support
6. How much support can your friends provide?
   No support 1 2 3 4 5 Much support
7. What is the hardest part about managing your weight?
   _____
8. What do you believe will be of most help to assist you in losing weight? _____
9. How confident are you that you can lose weight at this time?
   Not confident 1 2 3 4 5 Very confident

Weight history

10. As best as you can recall, what was your body weight at each of the following time points (if they apply)?
    Grade school _____ High school _____ College _____ Ages 20-29 _____ 30-39 _____ 40-49_____ 50-59_____
11. What has been your lowest body weight as an adult?_____ What has been your heaviest body weight as an adult? _____
12. At what age did you start trying to lose weight?_____
13. Please check all previous programs you have tried in order to lose weight. Include dates and your length of participation.

Program	Date	Weight (lost or gained)	Length of participation
• TOPS			
• Weight Watchers			
• Overeaters Anonymous			
• Liquid diets (eg, Optifast)			
• Diet pills: Meridia, Xenical			
• Diet pills: phen-fen, Redux,			
• NutriSystem / Jenny Craig			
• OTC diet pills			
• Obesity Surgery			
• Registered Dietitian			
• Other			

14. Have you maintained any weight loss for up to 1 year on any of these programs? Yes ☐ No ☐
15. What did you learn from these programs regarding your weight? _____
16. What did not work about these programs? _____
17. Have you been involved in physical activity programs to help with weight loss? Yes ☐ No ☐
    Which ones or in what way? _____

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Coping Lifestyle Patterns Mini-Quiz

Patient name: _____ **Date:** _____

Directions: For each question, read the pattern description. If a pattern seems to describe you, put a check in the Yes box. When you finish, look at your quiz. If you checked Yes for more than one pattern, go back and put a star by the two patterns that you think best describe you.

Coping Pattern	Pattern Description	This Describes Me
1. Are you an Emotional Eater?	You turn to food for comfort when you're stressed, anxious, lonely, or depressed.	Yes ☐ No ☐
2. Are you a Self-Scrutinizer?	You feel ashamed of your body and can be your own worst enemy in terms of thinking negative thoughts about yourself.	Yes ☐ No ☐
3. Are you a Persistent Procrastinator?	You keep putting off losing weight and can never seem to get started.	Yes ☐ No ☐
4. Are you a People Pleaser?	You keep saying yes to everyone else, which keeps your own needs at the bottom of your "to do" list.	Yes ☐ No ☐
5. Are you a Fast Pacer?	You are juggling so many things in your hectic pace of life and don't know how to slow it down and take time for yourself.	Yes ☐ No ☐
6. Are you a Doubtful Dieter?	You doubt that any new weight loss approach will work because nothing has helped in the past.	Yes ☐ No ☐
7. Are you an Overreaching Achiever?	You feel disappointed even when you're making progress, and you have a hard time living up to your own high expectations.	Yes ☐ No ☐

Eating Lifestyle Patterns Mini-Quiz

Patient name: _____ **Date:** _____

Directions: For each question, read the pattern description. If a pattern seems to describe you, put a check in the Yes box. When you finish, look at your quiz. If you checked Yes for more than one pattern, go back and put a star by the two patterns that you think best describe you.

Eating Pattern	Pattern Description	This Describes Me
1. Are you a Meal Skipper?	You don't plan your meals or eat on a set schedule, and you often end up skipping meals.	Yes ☐ No ☐
2. Are you a Nighttime Nibbler?	You eat little during the day, and have most meals and snacks from dinnertime onward.	Yes ☐ No ☐
3. Are you a Convenient Diner?	You eat foods that are convenient, ready-made, packaged, frozen, and microwavable; many of these foods are ordered in or taken out from a restaurant.	Yes ☐ No ☐
4. Are you a Fruitless Feaster?	You eat few fresh fruits and vegetables.	Yes ☐ No ☐
5. Are you a Steady Snacker?	You mindlessly snack on foods throughout the day, whether you are hungry or not.	Yes ☐ No ☐
6. Are you a Hearty Portioner?	You eat too much food too fast; you don't know when to stop eating until it's too late and you feel stuffed.	Yes ☐ No ☐
7. Are you a Swing Eater?	You swing between eating "good" foods in public and overeating "bad" foods in private, and this diet leaves you never feeling satisfied.	Yes ☐ No ☐

Exercise Lifestyle Patterns Mini-Quiz

Patient name: _____ **Date:** _____

Directions: For each question, read the pattern description. If a pattern seems to describe you, put a check in the Yes box. When you finish, look at your quiz. If you checked Yes for more than one pattern, go back and put a star by the two patterns that you think best describe you.

Exercise Pattern	Pattern Description	This Describes Me
1. Are you a Couch Champion?	You don't like to exercise and spend most of your leisure time doing sedentary activities or relaxing on the couch.	Yes ☐ No ☐
2. Are you an Uneasy Participant?	You are not comfortable exercising around others, and this keeps you from going to a gym or exercising in public.	Yes ☐ No ☐
3. Are you a Fresh Starter?	You don't know the first thing about how to start an exercise program, but you are willing to learn with the proper instruction.	Yes ☐ No ☐
4. Are you an All-or-Nothing Doer?	You're either "on" or "off" when it comes to exercise—sometimes you work out excessively, sometimes you are completely sedentary.	Yes ☐ No ☐
5. Are you a Set-Routine Repeater?	You've been doing the same exercise routine for the past 3 months (or longer) without varying the type, duration, or intensity of exercise.	Yes ☐ No ☐
6. Are you a Tender Bender?	You have pain, an injury, or a condition that restricts what you can and cannot do in an exercise program.	Yes ☐ No ☐
7. Are you a Rain Check Athlete?	You know you need to exercise and you want to, but you can't seem to find the time to fit it into your busy schedule.	Yes ☐ No ☐

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

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In depth Questions

Eating Habits

Do you skip meals? **(Circle one)** Yes or No

If so, which meal(s)?

Breakfast Lunch Dinner

Why do you skip meals? (Check all that apply)

- ☐ Too busy to eat
- ☐ Not hungry at that time
- ☐ Lack of food
- ☐ Can't think of what to eat
- ☐ Other

Do you feel hungry in the morning? **(Circle one)** Yes or No

When do you feel hungriest? (Rate 1-5, 1 being when you are hungriest)

Early Morning Mid Morning Noon Mid Afternoon Evening Late night

What tends to be your largest meal?

Breakfast Lunch Dinner

What unhealthy food(s) do you struggle with the most to avoid eating?

_____

_____

Healthy Habits

How often do you check your weight?

Never <Once a week >1/ week Daily

Do you currently keep a food log? Yes or No

How you ever kept a food log? Yes or No

If yes, was convenient was it for you to keep a food log? (Circle one)

Very convenient Somewhat convenient Very inconvenient

Self-Care Inventory

How many hours of sleep do you get nightly?

<7 hours/ night >7 hours/ night >9 hours/ night

Do you snore when you sleep or stop breathing while sleeping?

Yes or No

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How would you rate your current stress level?

None	Mild: A little stress but not interfering with daily life	Moderate: A lot on your plate you can handle	Severe: Overwhelming amount of stress

Is spirituality important to you? Yes or No
If YES: How do you practice your spirituality_____
If NO: How do you center yourself?_____

Do you currently or have history of use any of the following drugs?
Marijuana Cocaine Heroin Other_____

Medical History

Have you ever been pregnant? Yes or No
How many times? _____ When was your last pregnancy? ____
How many children do you have and what age(s)?

_____

Bariatric Surgery

Are you currently considering bariatric surgery? YES NO

- If so how soon?_____
- What type? _____
- Surgeon?_____