Department of Lifestyle Medicine Questionnaire

100 River Street, Suite 2 | 802-886-8928

First Name: ______ Last Name: ______

Phone: ______ Today's Date: ______ Date of Birth (mm/dd/yyyy): ______

Mailing Address: ______ City: ______ State: ______

Zip: ______ Email: ______

What is your preferred means of contact?

Phone ☐ Email ☐ Text ☐

What prompted you to seek services at this time?

Nutrition☐ Sleep☐ Depression☐ Cardiovascular health☐ Diabetes care☐

Weight management☐ Stress Management ☐ Other: ______

Who referred you to Lifestyle Medicine? ______

SLEEP QUALITY

Over the past two weeks, how many hours of continuous sleep did you average in a 24-hour period?

7 or more☐1 About 6 hours☐2 About 4-5 hours☐3 Less than 4 hours☐4

Over the past two weeks, how often did you feel tired or have difficulty staying awake during the day?

Not at all☐1 Several days☐2 More than half the days☐3 Nearly every day☐4

How many times do you wake up during your sleeping hours?

Zero -1☐1 2-3☐2 More than 3☐3

How often have you used sleeping aids (i.e., medication(s), alcohol, TV) to help you fall asleep?

Not at all☐1 Several days☐2 More than half the days☐3 Nearly every day☐4

Do you have a medical condition that interferes with your sleep?

No☐0 Yes☐1

How many days of the week do you go to sleep at the same hour?

Nearly every day☐1 More than half the days☐2 Several days☐3 None☐4

How many days of the week do you wake up at the same hour (within 30 minutes)?

Nearly every day☐1 More than half the days☐2 Several days☐3 None☐4

How would you rate the quality of your sleep?

Excellent☐1 Good☐2 Fair☐3 Poor☐4

Do you wake up feeling refreshed?

No☐1 Yes☐0

STRESS

How often have you felt that you were unable to control the important things in your life?

Never☐1 Seldom☐2 Sometimes☐3 Often☐4 Always☐5

How often have you felt a lack of confidence about your ability to handle your personal problems?

Never☐1 Seldom☐2 Sometimes☐3 Often☐4 Always☐5

How often have you felt that things were not going your way?

Never☐1 Seldom☐2 Sometimes☐3 Often☐4 Always☐5

How often have you found it hard to let go of things that upset you?

Never☐1 Seldom☐2 Sometimes☐3 Often☐4 Always☐5

How do you cope with stress? (Check all that apply)

Meditation☐ Prayer☐ Exercise☐ Talking with friend☐ Talking with family member☐ Talking with mental health professional☐ Socializing☐ Art☐ Food/Eating too little or too much☐ Sex☐ Television or video games☐ Gambling☐ Journaling☐ Massage therapy☐ Substance use (e.g., tobacco, alcohol)☐ Recreational drugs (e.g., marijuana, cocaine, etc.)☐ Pet therapy ☐

SOCIAL LIFE

During the past two weeks, have you spent a satisfactory amount of face-to-face time with friends, relatives, or other significant adults living outside of your home?

Yes☐0 Unsure☐1 No☐2

Do you have someone to turn to for emotional support?

Yes☐0 Unsure☐1 No☐2

Do you have someone to turn to for assistance?

Yes☐0 Unsure☐1 No☐2

Do you feel that people in your life do not care for you?

No☐0 Unsure☐1 Yes☐2

Do you feel that you do not belong to your community?

No☐0 Unsure☐1 Yes☐2

Do you feel that people are around you but not with you?

No☐0 Unsure☐1 Yes☐2

Do you feel rejected by those around you?

No☐0 Unsure☐1 Yes☐2

Do you feel there are few or no people you can trust?

No☐0 Unsure☐1 Yes☐2

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DEPRESSION

Over the last 2 weeks, how often have you been bothered by the following problems?

Little interest or pleasure in doing things

Not at all☐$_0$ Several days☐$_1$ More than half the days☐$_2$ Nearly every day☐$_3$

Feeling down, depressed, or hopeless

(Not at all☐$_0$ Several days☐$_1$ More than half the days☐$_2$ Nearly every day☐$_3$

Trouble falling or staying asleep, or sleeping too much

Not at all☐$_0$ Several days☐$_1$ More than half the days☐$_2$ Nearly every day☐$_3$

Feeling tired or having little energy

Not at all☐$_0$ Several days☐$_1$ More than half the days☐$_2$ Nearly every day☐$_3$

Poor appetite or overeating

Not at all☐$_0$ Several days☐$_1$ More than half the days☐$_2$ Nearly every day☐$_3$

Feeling bad about yourself or that you are a failure or have let yourself or your family down

Not at all☐$_0$ Several days☐$_1$ More than half the days☐$_2$ Nearly every day☐$_3$

Trouble concentrating on things, such as reading the newspaper or watching television

Not at all☐$_0$ Several days☐$_1$ More than half the days☐$_2$ Nearly every day☐$_3$

Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual

Not at all☐$_0$ Several days☐$_1$ More than half the days☐$_2$ Nearly every day☐$_3$

Thoughts that you would be better off dead, or of hurting yourself

Not at all☐$_0$ Several days☐$_1$ More than half the days☐$_2$ Nearly every day☐$_3$

PHYSICAL ACTIVITY

In general, how much do you enjoy being physically active?

A great deal☐$_1$ Quite a bit☐$_2$ Somewhat☐$_3$ Very Little☐$_4$ Not at all☐$_5$

During the last two weeks, how many times did you exercise at a ***moderate to strenuous intensity*** (e.g., enough movement to break at least a light sweat)?

5 or more times per week☐$_1$ 3-4 times per week☐$_2$ 1-2 times per week☐$_3$ Zero☐$_4$

During an average session, how many minutes do you exercise at a ***moderate to strenuous intensity***?

50 minutes or more☐$_1$ 30-49 mins☐$_2$ 10-29 mins☐$_3$ Less than 10 min☐$_4$

What makes it difficult for you to exercise?

Lack of time☐ No facility☐ Cost☐ Physical restrictions☐ No interest☐ No one to exercise with☐ Self-conscious☐

When you exercise or exert yourself, do you experience any of the following?

Shortness of breath☐ Chest pain or pressure☐ Pain in lower leg(s)☐ No concerning symptoms☐

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PAIN

In the past 7 days, how much did pain interfere with your enjoyment of life?

Not at all☐1 A little bit☐2 Somewhat☐3 Quite a bit☐4 Very much☐5

In the past 7 days, how much did pain interfere with your ability to concentrate?

Not at all☐1 A little bit☐2 Somewhat☐3 Quite a bit☐4 Very much☐5

In the past 7 days, how much did pain interfere with your day-to-day activities?

Not at all☐1 A little bit☐2 Somewhat☐3 Quite a bit☐4 Very much☐5

In the past 7 days, how much did pain interfere with your enjoyment of recreational activities?

Not at all☐1 A little bit☐2 Somewhat☐3 Quite a bit☐4 Very much☐5

In the past 7 days, how much did pain interfere with doing your tasks away from home (e.g., getting groceries, running errands)?

Not at all☐1 A little bit☐2 Somewhat☐3 Quite a bit☐4 Very much☐5

In the past 7 days, how often did pain keep you from socializing with others?

Never☐1 Rarely☐2 Sometimes☐3 Often☐4 Always☐5

ANXIETY

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

Feeling nervous, anxious, or on edge

Not at all☐0 Several days☐1 More than half the days☐2 Nearly every day☐3

Not being able to stop or control worrying

Not at all☐0 Several days☐1 More than half the days☐2 Nearly every day☐3

Worrying too much about different things

Not at all☐0 Several days☐1 More than half the days☐2 Nearly every day☐3

Trouble relaxing

Not at all☐0 Several days☐1 More than half the days☐2 Nearly every day☐3

Being so restless that it's hard to sit still

Not at all☐0 Several days☐1 More than half the days☐2 Nearly every day☐3

Becoming easily annoyed or irritable

Not at all☐0 Several days☐1 More than half the days☐2 Nearly every day☐3

Feeling afraid as if something awful might happen

Not at all☐0 Several days☐1 More than half the days☐2 Nearly every day☐3

First Name: ☐ Last Name: ☐ Date of Birth: ☐

EATING PATTERNS

Please read each statement and select from the multiple choice options the answer that indicates the frequency with which you find yourself feeling or experiencing what is being described in the statements below.

1. When I smell a delicious food, I find it very difficult to keep from eating, even if I have just finished a meal.
Definitely true☐4 Mostly true☐3 Mostly false☐2 Definitely false☐1

2. I deliberately take small helpings as a means of controlling my weight.
Definitely true☐4 Mostly true☐3 Mostly false☐2 Definitely false☐1

3. When I feel anxious, I find myself eating.
Definitely true☐4 Mostly true☐3 Mostly false☐2 Definitely false☐1

4. Sometimes when I start eating, I just can't seem to stop.
Definitely true☐4 Mostly true☐3 Mostly false☐2 Definitely false☐1

5. Being with someone who is eating often makes me hungry enough to eat also
Definitely true☐4 Mostly true☐3 Mostly false☐2 Definitely false☐1

6. When I feel blue, I often overeat.
Definitely true☐4 Mostly true☐3 Mostly false☐2 Definitely false☐1

7. When I see a real delicacy, I often get so hungry that I have to eat right away.
Definitely true☐4 Mostly true☐3 Mostly false☐2 Definitely false☐1

8. I get so hungry that my stomach often seems like a bottomless pit.
Definitely true☐4 Mostly true☐3 Mostly false☐2 Definitely false☐1

9. I am always hungry so it is hard for me to stop eating before I finish the food on my plate.
Definitely true☐4 Mostly true☐3 Mostly false☐2 Definitely false☐1

10. When I feel lonely, I console myself by eating.
Definitely true☐4 Mostly true☐3 Mostly false☐2 Definitely false☐1

11. I consciously hold back at meals in order not to weight gain.
Definitely true☐4 Mostly true☐3 Mostly false☐2 Definitely false☐1

12. I do not eat some foods because they make me fat.
Definitely true☐4 Mostly true☐3 Mostly false☐2 Definitely false☐1

13. I am always hungry enough to eat at any time.
Definitely true☐4 Mostly true☐3 Mostly false☐2 Definitely false☐1

14. How often do you feel hungry?
Only at meal times ☐1 Sometimes between meals☐2 Often between meals☐3 Almost always☐4

15. How frequently do you avoid "stocking up" on tempting foods?
Almost never ☐1 Seldom ☐2 Usually ☐3 Almost always ☐4

16. How likely are you to consciously eat less than you want?
Unlikely ☐1 Slightly likely ☐2 Moderately likely☐3 Very likely ☐4

17. Do you go on eating binges though you are not hungry?
Never ☐1 Rarely ☐2 Sometimes ☐3 At least once a week ☐4

18. On a scale of 1 to 8, where 1 means no restraint in eating (eating whatever you want, whenever you want it) and 8 means total restraint (constantly limiting food intake and never "giving in"), what number would you give yourself?
1-2☐1 3-4☐2 5-6☐3 7-8☐4

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NUTRITION

How often during the week do you cook meals from scratch? (One choice)

All meals☐$_0$ Almost every meal☐$_1$ Sometimes☐$_2$ Almost never☐$_3$ Never☐$_4$

How often during the week do you eat in restaurants or order take out? (One choice)

All meals☐$_0$ Almost every meal☐$_1$ Sometimes☐$_2$ Almost never☐$_3$ Never☐$_4$

Do you read food labels?

Yes☐$_0$ Sometimes☐$_1$ Never☐$_2$

When you eat with others, do you usually finish before they do?

Never or almost never☐$_0$ Sometimes☐$_1$ Usually or Always☐$_2$

Do you eat until you feel physically uncomfortably?

Never or almost never☐$_0$ Sometimes☐$_1$ Usually or Always☐$_2$

Do you eat when you are not feeling physically hungry?

Not usually☐$_0$ Sometimes☐$_1$ Frequently☐$_2$

Do you feel guilty after eating?

Not usually☐$_0$ Sometimes☐$_1$ Frequently☐$_2$

Do you prefer to eat alone so that others don't see how much you are eating?

Not usually☐$_0$ Sometimes☐$_1$ Frequently☐$_2$

Have you ever been diagnosed with an eating disorder?

No☐$_0$ Yes☐$_1$

If yes, which one?

Compulsive overeating☐ Binge eating disorder☐ Anorexia / bulimia☐

Do you feel that you do not have control over your food intake?

No☐$_0$ Unsure☐$_1$ Yes☐$_2$

What type of beverage do you primarily drink during the day? (one choice)

Soda☐ Coffee☐ Water☐ Nothing, tea, juice☐

Do have any dietary restrictions?

No☐ Yes☐

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WEIGHT HISTORY

What is the maximum amount of weight you have gained during one period in the past 5 years?

0-10☐ 11-20☐ 21-30☐ 31-40☐ 41 or more☐

What is the maximum amount of weight you have lost during one period in the past 5 years?

0-10☐ 11-20☐ 21-30☐ 31-40☐ 41 or more☐

Have you previously participated in a weight loss program?

Yes☐ No☐

Have you previously seen a Registered Dietician (RD)?

Yes☐ No☐

Have you at any point in time undergone weight loss surgery?

Yes☐ No☐

Do you consider yourself underweight, appropriately weighted, or overweight?

Underweight☐ Appropriate weight☐ Overweight☐

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ALCOHOL USE

How often did you have a drink containing alcohol in the past year?

Never ☐0 Monthly or less☐1 2 to 4 times a month ☐2 2 to 3 times a week ☐3 4 or more times per week ☐4

How many drinks did you have on a typical day when you were drinking in the past year?

None, I don't drink ☐0 1 or 2 ☐0 3 or 4 ☐1 5 or 6 ☐2 7 to 9 ☐3 10 or more ☐4

How often did you have six or more drinks on one occasion in the past year?

Never ☐0 Less then monthly ☐1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☐4

READINESS

Thinking about your physical activity and eating over the past three months, please answer the following:

I eat healthily

Strongly disagree☐5 Disagree☐4 Not sure☐3 Agree☐2 Strongly agree☐1

I get enough physical activity

Strongly disagree☐5 Disagree☐4 Not sure☐3 Agree☐2 Strongly agree☐1

I want to eat more healthily

Strongly agree☐5 Agree☐4 Not sure☐3 Disagree☐2 Strongly disagree☐1

I want to be more physically active

Strongly agree☐5 Agree☐4 Not sure☐3 Disagree☐2 Strongly disagree☐1

How confident are you that you can make changes right now regarding:

Getting physical activity more often and for longer periods of time

I am sure I can☐4 I think I can☐3 I am not sure I can☐2 I don't think I can☐1

Eating more healthful foods

I am sure I can☐4 I think I can☐3 I am not sure I can☐2 I don't think I can☐1

Overeating less often

I am sure I can☐4 I think I can☐3 I am not sure I can☐2 I don't think I can☐1