Name: _____ **Medical Record #:** _____

Date of Birth: _____

PRE-PROGRAM QUESTIONNAIRE

INSTRUCTIONS:

Please answer each question in this questionnaire and the enclosed medical history.

Bring the completed forms to your Part 1 Medical Assessment Appointment in order to schedule your Part 2 Medical Assessment and Body Assessment appointments.

KAISER PERMANENTE®

Positive Choice Integrative Wellness Center
7035 Convoy Court
San Diego, CA 92111
(858) 573-0090

Welcome to the Positive Choice Wellness Center!

We are happy that you have made the decision to join our Weight Management Program. While you are with us at Positive Choice, we want to make sure that you receive the highest quality care possible and make the maximum progress towards the goals that brought you into the program.

In order for this to happen, we need to gather some information about you. We recognize that some of the questions we ask are quite personal. However, experience and research has taught us that a person's relationship with food is not a coincidence. Rather it is the result of life experiences and how we think and feel about them.

While you may not have thought about it before, making the connection between past experiences and how your life is working today is important to achieving any goal you set for yourself. Answering the following questions honestly can be an important first step towards increasing your self-awareness, enhancing your self-confidence, and achieving your weight management goals.

Some of the information you give us may become part of your Kaiser Permanente health record, but will only be viewed by your counselor and the medical staff at Kaiser Permanente and only for the purpose of helping you reach your weight goals and improve your well-being. This information cannot be used in any other way or seen by anyone else without your written consent.

Sincerely yours,

Michael Moreno, MD

CONFIDENTIAL

In order to assist you in the difficult endeavor of permanent weight management, we need certain information. All information received is confidential.

Weight Loss Goals

1. Have you previously enrolled in the Positive Choice Weight Management Program?

   _____ yes _____ no If yes, how many times? _____

2. How much weight do you hope to lose in this program? _____ lbs.

3. What is the most you have ever weighed?

   _____ lbs. at _____ yrs. old

4. What is the largest amount of weight you've ever lost? _____ lbs. at _____ years old.

5. How long before you started to regain? _____

6. *WHY* did you eat to regain? _____

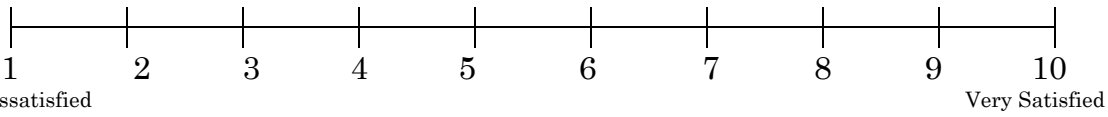
   _____

   _____

Background

7. Occupation: _____

   On a scale of 1 to 10, how satisfied are you with your current employment? (Circle one.)



8. Is there any age or period of time for which you have no memory or are amnesic?

   _____ yes _____ no If yes, when: _____

9. For each time period shown (on the following page), please list your maximum weight. If you cannot remember what your maximum weight was, make your best guess.

	Age	Wt.	Identify additional important life events and changes (births, deaths, marriages, divorces, injury, illness, military service, etc.)
Birth	N/A		
Kindergarten			
6th grade			
9th grade			
1st sexual activity			
12th grade			
17–21			
21–25			
26–35			
36–50			
51–60			
61–70			
71–80			
Over 80			

10. Have you ever had any significant physical symptoms or emotional reactions while attempting to lose weight or after losing weight?

    _____ yes _____ no

    If yes, please describe your symptoms or reactions, when they occurred, and the type of professional help you sought, if any.

    _____

    _____

11. Have you ever had problems at any time with: (check all that apply)

    ___ depression
    ___ anxiety
    ___ being more sensitive than others
    ___ panic attacks
    ___ disturbed sleep
    ___ anger
    ___ rage attacks

12. Have you ever been suicidal? _____ yes _____ no

13. Have you ever been treated by a psychiatrist and/or psychotherapist?

_____ yes _____ no

14. Please score the questions in this section using the 0 to 3 scale below:

0 = none at all

1 = several days

2 = more than half the days

3 = nearly every day

_____ a. Have you lost interest or pleasure in doing things?

_____ b. Have you been feeling down, depressed, or hopeless?

_____ c. Do you have trouble falling or staying asleep or sleeping too much?

_____ d. Have you been feeling tired or lacking energy?

_____ e. Have you had a poor appetite or have you been overeating?

_____ f. Have you been feeling bad about yourself or that you are a failure or have let yourself or your family down?

_____ g. Do you have trouble concentrating on things such as reading the newspaper or watching television?

_____ h. Have you been moving/speaking slowly so others have noticed or been fidgety/restless more than usual?

_____ i. Lately, have you thought that you would be better off dead or though of hurting yourself in some way?

Scoring for question below (please circle one):

Extremely difficult Very difficult

Somewhat difficult Not difficult at all

j. How hard have these problems made it for you to work, tend to things at home, or get along with others?

Self-Perceptions

15. Can you comfortably accept compliments about weight loss?

_____ yes _____ no

Can you comfortably accept compliments from:

the opposite sex? the same sex?

_____ yes _____ no _____ yes _____ no

How do you think your life will change if you lose enough weight?

_____

_____

Use of Other Substances

16. Do you smoke cigarettes? _____ yes _____ no

If yes, how many cigarettes per day?_____

17. Do you drink alcohol? _____ yes _____ no

If yes, how much alcohol (e.g., wine, beer, mixed drinks) do you drink in a day?

_____

18. Have you used alcohol in the past? _____ yes _____ no

If yes, please describe _____

_____

19. Do you use street drugs or abuse prescription drugs? _____ yes _____ no

If yes, please describe substance and frequency _____

_____

20. Have you used street drugs or abused Rx drugs in the past? _____ yes_____ no

If yes, please describe _____

_____

Eating Habits

21. When completing the items in this section, please use the 5-point scale below. Pick the one number that best describes how true the observation is for you.

1 = not true at all
2 = occasionally true
3 = often true
4 = mostly the case
5 = always the case

I have noticed that my *eating* may:
__ diminish anxiety, insecurity, tension, worry.
__ help me achieve pleasure, social success, acceptance.
__ relieve frustration, discouragement.
__ reward me for something accomplished.
__ help me avoid competition, not changing the status quo.
__ help me avoid maturity.
__ help me test love and affection.
__ be a way to identify with a fat parent.
__ substitute for love and affection.
__ substitute for sexual activity.
__ be a way to sedate myself.
__ help me avoid depression.

22. When completing the items in this section, please use the 5-point scale below. Pick the one number that best describes how true the observation is for you.

1 = not true at all
2 = occasionally true
3 = often true
4 = mostly the case
5 = always the case

I have noticed that my *obesity* may:
__ be a means of avoiding contact with certain people.
__ be a way of justifying not doing certain things.
__ protect me from sexual activity.
__ reduce demands and expectations put upon me.
__ satisfy other people.
__ justify failure in certain areas of life.
__ make me seem a more powerful person to others.
__ be an act of defiance.
__ be an act of submission.
__ be a way to make myself invisible.

23. After eating, have you ever forced yourself to vomit?

_____ yes _____ no

What feelings or experiences triggered this?

_____

_____

_____

24. Do you use diuretics or laxatives to help control your weight?

_____ yes _____ no

Physical Activity

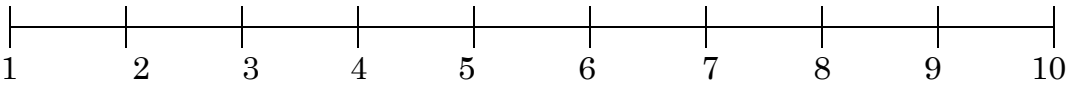
25. Is there any physical activity you engage in regularly?

_____ yes _____ no

Please describe it:

_____

On a scale of 1 to 10, how much do you enjoy this activity?



Really hate to do it — Really enjoy it a lot

Family Overview

26. Who currently lives with you in your household?
Specify your relationship to each.

_____

_____

_____

_____

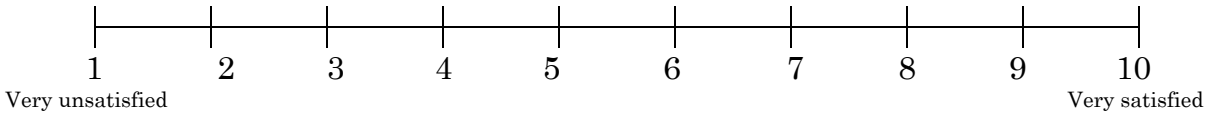
27. Are you currently: (circle one)

Single Widowed Married Divorced

In a Live-in or Committed Relationship Other

28. How many times have you been married? _____

29. If you are married or in an intimate relationship, on a scale of 1 to 10, how satisfied are you with this relationship?



30. Please describe what this person does either to support or hinder your efforts to lose weight.

_____

_____

31. Who in your *current family*:
is overweight or obese? _____
is depressed? _____
drinks heavily? _____
uses street drugs? _____
is having problems with the law? _____
is experiencing employment/unemployment problems? _____
is having other problems? Specify problem: _____

32. Has a close relative ever attempted suicide? ___ yes ___ no

Committed suicide? ___ yes ___no

If yes, who? _____

33. Circle the words below that describe how you handle disagreements with the people you are closest to:

withdraw reason negotiate shout argue discuss hit cry

leave give in threaten ridicule avoid ignore pout other_____

34. Who will support your efforts to lose weight? _____

35. Who will hinder your efforts to lose weight?_____

36. Do you have someone with whom you share your innermost thoughts and feelings?

_____ Yes _____ No If yes, who? _____

Childhood Overview

37. Describe the family in which you were raised by circling the appropriate words:

warm distant cruel battling destructive
loving uninterested rigid other _____

38. Were the people who raised you:

Concerned about your worries?	_____Yes	_____No
Interested in how you did in school?	_____Yes	_____No
Able to make you feel wanted?	_____Yes	_____No
Often critical of you?	_____Yes	_____No
Interested in who your friends were?	_____Yes	_____No
There if you needed help or support?	_____Yes	_____No

39a. Did a parent or other adult in the household **often** or **very often** swear at you, insult you, put you down, or humiliate you?

_____Yes _____No

39b. Did a parent or other adult in the household **often** or **very often** act in a way that made you afraid that you might be physically hurt?

_____Yes _____No

40a. Did a parent or other adult in the household **often** or **very often** push, grab, slap, or throw something at you? _____Yes _____No

40b. Did a parent or other adult in the household ever hit you so hard that you had marks or were injured? _____Yes _____No

41. Describe how you were raised has affected you?

_____

_____

42. Were *both* your biological parents the ones who raised you?

_____ Yes _____ No

If no, who raised you? _____

43. Were your parents **ever** separated or divorced before you turned 18 years old?

_____ Yes _____ No

44a. In the family that you grew up with, who had a history of depression or anxiety which disrupted normal functioning?

_____

_____

44b. In the family that you grew up with, who used street drugs?

_____

Was a heavy drinker?

_____

44c. Who in the family that you grew up with had problems with the law?

_____

Went to prison?

_____

Had other serious problems?

_____

45a. In the family that you grew up with, did you **often** or **very often** feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect you? _____Yes _____No

45b In the family that you grew up with, did you **often** or **very often** feel that your parents were too drunk or high to take care of you or take you to the doctor if you needed it? _____Yes _____No

46. Before you were 18 years of age, was your mother or stepmother:

    a. **Often** or **very often** pushed, grabbed, slapped, or had something thrown at her? _____Yes _____No

    b. **Sometimes, often,** or **very often** kicked, bitten, hit with a fist, or hit with something hard? _____Yes _____No

    c. **Ever** repeatedly hit for at least a few minutes or threatened with a gun or knife? _____Yes _____No

47. Please place an X under the category that most closely resembles the size of the following individuals during your *childhood years up to 18 years of age*:

	Normal Wt.	Overweight	Obese
Mother			
Father			
Caretaker(s) (if other than mother/father)			
Brother(s)			
Sisters(s)			

48. Who among these individuals is leading a troubled life currently?

    _____

    _____

49. As a child (up to 18 years of age) were you: (check all that apply)

    _____ frequently ridiculed?
    _____ complimented?
    _____ frequently criticized?
    _____ encouraged?
    _____ frequently beaten?
    _____ given affection?
    _____ understood?
    _____ given attention?

50. During your childhood (up to 18 years of age) did you **often** or **very often** feel that …

    a. No one in your family loved you or thought you were important or special? _____Yes _____No

    b. Your family didn't look out for each other, feel close to each other, or support each other? _____Yes _____No

    c. How do you think the way you were treated affected you?

    _____

    _____

51. a. Have you ever been sexually molested? _____ yes _____ no

    b. Prior to age 18? _____ yes _____ no

52. If you answered "yes" to 51b, did an adult or person ***at least 5 years older*** than you ever…

    a. Touch or fondle you or have you touch their body in a sexual way? _____Yes _____No

    b. Attempt or actually have oral, anal, or vaginal sex with you? _____Yes _____No

    c. How has this affected you later in life? _____

    _____

    _____

53. Have you ever been a victim of rape?

    _____ yes _____ no

    a. How old were you at the time? _____

    b. How has this affected you? _____

    _____

    _____

54. a. Before the age of 18, what do you think was the most significant negative event in your life?

_____

b. After the age of 18, what do you think was the most significant negative event in your life?

_____

c. Of the two events (54 a. and b.), which one had the greatest effect on your life and how?

_____

_____

Psychological Timing

55. Please circle if you are currently experiencing any stressful changes in your life related to the following events:

A. work
B. health
C. spouse or friend
D. children
E. parents
F. legal/financial trouble
G. school
H. moving
I. jealousy or infidelity
J. other

56. What do you think is the basic, underlying cause of your weight problem?

_____

_____

_____

_____

57. What do you hope to achieve in your life as a result of losing weight?

_____

_____

_____

_____

58. Do you anticipate any problems in relationships with others as a result of losing weight?

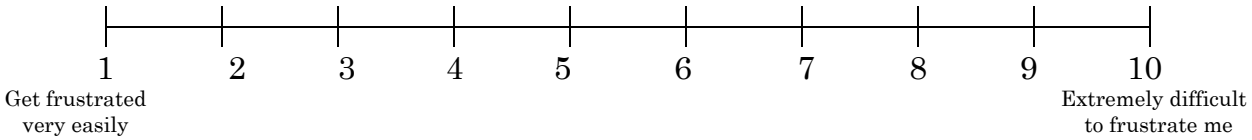
_____ yes _____ no

If yes, describe:

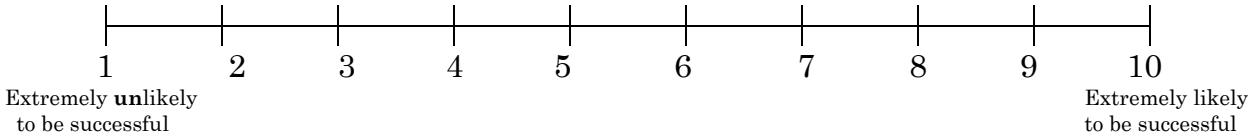
_____

_____

59. On a scale of 1 to 10, how easily do you get frustrated?

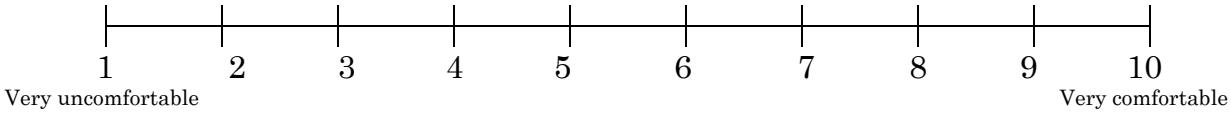


60. On a scale of 1 to 10, how likely are you to be successful ***at losing and keeping your weight off?***



Group Participation

61. On a scale of 1 to 10, how comfortable do you think you will feel discussing your eating and exercise habits with people in your group?



62. a. Is there anything about being in a group that worries you?

_____ yes _____ no

b. If yes, please describe briefly below.

_____

_____

_____

_____

_____

63. Please use the space below to discuss any other information you think is important to understanding your weight problem or your successful participation in the program.

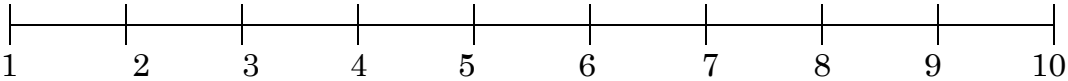
_____

_____

_____

_____

64. Thank you for your efforts thus far. On a scale of 1 to 10, please let us know how honestly you filled out this questionnaire.



_____ _____

Today's Date Signature