Welcome to TransforME!

You are entering one of the most comprehensive weight management program in the United States because you have a difficult problem to solve. This program will help you identify the necessary changes to promote lasting weight control. This is a Weight Management program that offers a choice of two weight loss programs. Both are easy to follow and we will work with you to customize the program to fit your specific needs. To help you transition to healthy eating during maintenance, you will have an individual meeting with a nutritionist. This is where the real work begins. Our group Lifestyle Intervention program known as Life2 will give you the knowledge, feedback and support you need to make lasting behavior changes. So we congratulate you on taking the first step. Obesity is a chronic disease which requires a lifelong commitment to changing behavior and we will be there for you as you make this transformation.

Before you begin the program, we need information from you to increase your likelihood for success. The attached questionnaire helps in three ways: it identifies those people who need support in addition to the basic program; it starts to organize your thinking along lines that other people find appropriate and necessary for long term weight management success; and it helps those professional involved with your care understand how best to help you.

Have you ever noticed a relationship between eating or obesity and other things in your life like anger or problems in relationships and sexuality? Have you ever found yourself with food in your mouth, soothing and numbing your emotions before they were even recognizable? Do you find yourself repeatedly eating, but don't understand why? Through the course of this one-year weight management program we are going to challenge you, to not only consider what you eat but also to consider what is eating you and how that effects your diet, self-esteem, happiness and ultimately your health. Our experience is that when people don't see the connection between overeating and other aspects of their life, they unconsciously return to using food as a coping mechanism and regain their weight. Our program will help you identify not just what you eat but why you eat and help give you the tools to make lasting changes to your diet, physical activity and lifestyle behaviors.

Please allow 30 minutes to complete this questionnaire. Rest assured that the information you provide will be kept confidential and will only be available to the treatment staff. Thank you for taking the time to complete this questionnaire.

Sincerely,

Bonnie Kanders, EdD, MEd, MPH
Director of Weight Management

LaJune Oliver, MD
Medical Director of Weight Management

KAISER PERMANENTE®

Kaiser Foundation Health Plan of Georgia, Inc.
Nine Piedmont Center
3495 Piedmont Road, N.E.
Atlanta, Georgia 30305-1736

61199010 12/18

Name: _____ Medical Record #: _____

Pre-Program Questionnaire

Instructions:

Please answer each question in this questionnaire as completely and honestly as you can. Bring the completed forms to your Medical Assessment appointment.

Kaiser Foundation Health Plan of Georgia, Inc.
Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, GA 30305

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In order to assist you in the difficult endeavor of permanent weight management, we need certain information. All information received is confidential and is used to determine what additional support, if any, is appropriate to insure your success.

BACKGROUND

1. Occupation: _____ Age: _____

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

1 2 3 4 5 6 7 8 9 10

3. What is the most you have ever weighed?

_____ lbs. at _____ yrs. old

4. What is the lowest weight, after age 21, which you maintained for at least one year?

_____lbs. at _____ yrs. old

5. 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.

For each of the periods, please also select the one figure from the bottom of page 3 which best portrays your figure or physique at this time. Write the number of the figure in the space provided. In addition, please note any events that coincide with your gaining weight during this period.

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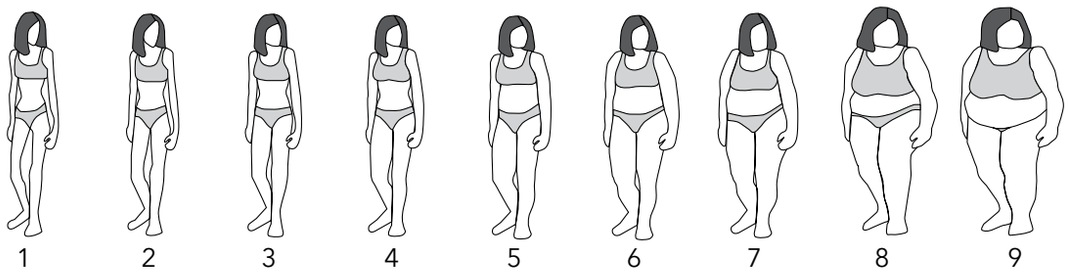
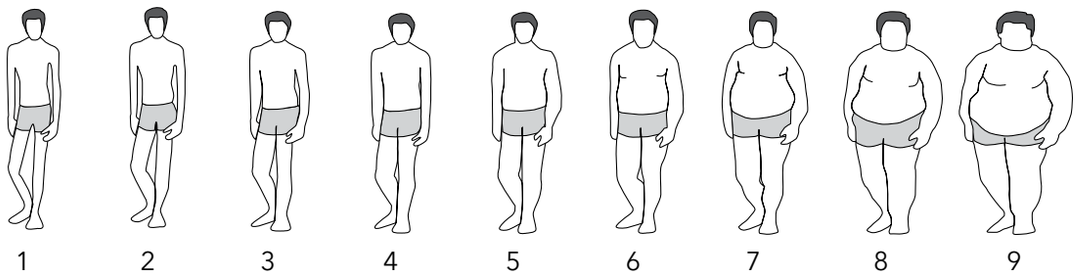
	AGE	WEIGHT	FIG. NO.	SIGNIFICANT EVENT(S) THAT OCCURRED
Birth				
Kindergarten				
6th grade				
Onset of menstruation				
9th grade				
First sexual activity				
12th grade				
17-21				
21-25				
26-35				
35-50				
Over 50				
Armed forces basic training				
Marriage #1 (start)				
Pregnancy with most weight gain: start				
End of pregnancy				
Marriage #2 (start)				





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6. 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.

_____

_____

7. 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

8. Have you ever been suicidal? ☐ yes ☐ no

9. Have you ever been treated by a psychiatrist and/or psychologist? ☐ yes ☐ no

Weight Loss Goals

10. What is your goal weight? _____

11. When did you last weigh this amount? _____

12. How long was this weight maintained? _____ months

13. Was it achieved after a weight loss effort? ☐ yes ☐ no

14. What is the largest amount of weight you've ever lost? _____ lbs.

a. How long did you go before starting to regain? _____

15. If you are successful in our program, in changing your eating and exercise habits, how much weight do you realistically expect to lose after

6 months _____lbs 12 months _____lbs

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

_____

_____

_____

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Use of Other Substances

17. Do you smoke cigarettes? ☐ yes ☐ no

If yes, how many cigarettes per day? _____

18. How much alcohol (e.g., wine, beer, mixed drinks) do you drink in a day?

_____

19. Have you used street drugs in the past? ☐ yes ☐ no

20. Are you presently using street drugs? ☐ yes ☐ no

Eating Habits

21. In answering this question, please use the 5-point scale below. Pick the one number that best describes how true the observation is for you.

I have noticed that my eating may:

	Not true at all	Occasionally true	Often true	Mostly the case	Always the case
Diminish anxiety, insecurity, tension, worry	1	2	3	4	5
Help me achieve pleasure, social success, acceptance	1	2	3	4	5
Relieve frustration, discouragement	1	2	3	4	5
Reward me for something accomplished	1	2	3	4	5
Help me avoid competition, not changing the status quo	1	2	3	4	5
Help me test love and affection	1	2	3	4	5
Be a way to identify with a fat parent	1	2	3	4	5
Substitute for love and affection	1	2	3	4	5
Substitute for sexual activity	1	2	3	4	5
Be a way to sedate myself	1	2	3	4	5
Help me avoid depression	1	2	3	4	5

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22. In answering this question, please use the 5-point scale below. Pick the one number that best describes how true the observation is for you.

I have noticed that my *obesity* may:

	Not true at all	Occasionally true	Often true	Mostly the case	Always the case
Be a means of avoiding contact with certain people	1	2	3	4	5
Be a way of justifying not doing certain things	1	2	3	4	5
Protect me from sexual activity	1	2	3	4	5
Reduce demands and expectations put upon me	1	2	3	4	5
Satisfy other people	1	2	3	4	5
Justify failure in certain areas of life	1	2	3	4	5
Make me seem a more powerful person to others	1	2	3	4	5
Be an act of defiance	1	2	3	4	5
Be an act of submission	1	2	3	4	5
Be a way to make myself invisible	1	2	3	4	5

Eating Patterns

23. After eating, have you ever forced yourself to vomit? ☐ yes ☐ no

24. What feelings or experiences triggered this? ☐ yes ☐ no

_____

_____

_____

25. Do you use diuretics or laxatives to help control your weight? ☐ yes ☐ no

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Physical Activity

26A. To what extent do you enjoy physical activity (check one)

☐ Not at all ☐ Slightly ☐ Moderately ☐ Greatly

26B. Do you have a bone or joint problem that could be made worse by a change in your physical activity? ☐ yes ☐ no

26C. Do you lose your balance because of dizziness or do you ever lose consciousness? ☐ yes ☐ no

26D. Do you know of any reason why you should not do physical activity? ☐ yes ☐ no

If yes, please list _____

27. Please check the types of physical activity that you enjoy. Check only those that you have participated in during the last year

☐ walking (outside)
☐ walking (indoor, including treadmill)
☐ jogging or running
☐ biking (outside)
☐ biking (stationary)
☐ aerobics class
☐ tennis racket sports
☐ swimming
☐ basketball
☐ golf
☐ dancing
☐ strength training

Other please describe_____

For your most preferred activity how many times have you participated in this activity in the past 6 months? _____ times

28. How many hours of TV do you watch on average week day? _____ hours

29. How many hours of TV do you watch on an average weekend day? _____ hours

30. Approximately how many city blocks or the equivalent do you regularly walk each day?

_____ blocks

31. How many flights of stairs do you climb each day _____ (1 flight =10 steps)

32. Please describe your daily lifestyle activity (i.e. how active you are) by picking any number from 1 to 10 in which 1= very sedentary and 10=very active. (check one)

1 2 3 4 5 6 7 8 9 10

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Family and Childhood History

33. Who lives with you in your adult household? Specify their relationship if not obvious.

_____

_____

_____

34. Are you currently: (check one)

☐ Single ☐ Widowed ☐ Married ☐ Separated ☐ Divorced ☐ In a Live-in Relationship

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

1 2 3 4 5 6 7 8 9 10

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

_____

_____

36. For your current family, please select the profile from page 3 that most closely resembles the profiles of the following individuals:

Spouse _____ Children _____

Others Living in your household, if not already identified _____

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

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

39. Please select the profile from page 3 that most closely resembles the size of the following individuals during your childhood years:

Mother ____ Father ____ Caretaker(s) (if other than mother or father) ____

Brother(s) ____ Sister(s) ___

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Eating Habits

40. How many days a week do you eat the following meals? Write the number of days in the space and the usual time of each meal.

	Days/week	Time
Breakfast		
Lunch		
Dinner		
Morning Snack		
Afternoon Snack		
Evening Snack		

41. Who prepares meals at your home? _____

42. Who does the food shopping? _____

43. Please list your five favorite foods_____

44. Do you have any food allergies Yes No. If yes, please specify _____

45. Please specify the amount (in cups, 8oz) of the following fluids you typically consume a day.

_____ skim milk _____ Fruit juice _____ beer _____ wine

_____ low fat milk _____ diet soda _____ water _____ hard liquor

_____ whole milk _____ tea _____ regular

_____ seltzer water _____ coffee _____ soda

_____ other (please list) _____

46. During a typical week, how many meals do you eat at a fast food restaurant (including drive through and convenience store)?

Breakfast _____ meals/week

Lunch _____ meals/week

Dinner _____ meals/week

47. During a typical week, how many meals do you eat at a traditional restaurant, coffee shop, cafeterias or similar establishment?

Breakfast _____ meals/week

Lunch _____ meals/week

Dinner _____ meals/week

48. How many times a week do you typically eat out with others (including family)? _____

Food intake Recall

Please indicate the foods you consume on a typical weekday

MEAL	TIME	LOCATION	FOOD AND BEVERAGES CONSUMED	AMOUNT
Breakfast				
Morning Snack				
Lunch				
Afternoon Snack				
Dinner				
Evening Snack				

Please indicate the foods you consume on a typical weekend day.

MEAL	TIME	LOCATION	FOOD AND BEVERAGES CONSUMED	AMOUNT
Breakfast				
Morning Snack				
Lunch				
Afternoon Snack				
Dinner				
Evening Snack				

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49. During the past 6 months did you often eat an unusually large amount of food within a two hour period (an amount that most people would agree is unusually large):

☐ yes ☐ no

50. During the times when you ate an unusually large amount of food, did you often feel you could not stop eating or control what or how much you were eating

☐ yes ☐ no

If no, do not complete question 3-10

51. During the past 6 months, how often, on average, did you have times when you ate unusually large amounts of food and felt that your eating was out of control? (There may have been some weeks when it was not present-just average those in) check one

☐ Less than one day a week

☐ One day a week

☐ Two or three days a week

☐ Four or five days a week

☐ Nearly every day

52. Did you usually have any of the following experiences during these occasions? Complete all items by checking yes or no.

Eating much more rapidly than usual?	☐ yes	☐ no
Eating until you felt uncomfortably full?	☐ yes	☐ no
Eating large amounts of food when you didn't feel physically hungry?	☐ yes	☐ no
Eating alone because you were embarrassed by how much you were eating?	☐ yes	☐ no
Feeling disgusted with yourself, depressed or feeling very guilty after overeating?	☐ yes	☐ no
Eating large amounts of food throughout the day with no planned mealtimes?	☐ yes	☐ no

53. Think about a typical time when you ate this way (that is, large amounts of food and feeling that your eating was out of control).

What time of day did the episode start? (check one)

☐ Morning 8-12 Noon

☐ Early afternoon (12 Noon to 4pm)

☐ Late afternoon (4pm to 7 pm)

☐ Evening (7 pm to 10 pm)

☐ Night (After 10 pm)

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Psychological Timing

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

- ☐ Work
- ☐ Health
- ☐ Spouse or friend
- ☐ Children
- ☐ Parents
- ☐ Legal/financial trouble
- ☐ School
- ☐ Moving
- ☐ Jealousy or infidelity
- ☐ Other

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

_____

_____

_____

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

_____

_____

_____

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

☐ yes ☐ no

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

1 2 3 4 5 6 7 8 9 10

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

1 2 3 4 5 6 7 8 9 10

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60. 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?

1 2 3 4 5 6 7 8 9 10

61. Is there anything about being in a group that worries you? ☐ yes ☐ no

If yes, please describe briefly below.

_____

_____

_____

_____

62. 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.

_____

_____

_____

63. 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.

1 2 3 4 5 6 7 8 9 10

SIGNATURE _____

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