McLAREN FLINT
McLAREN BARIATRIC AND METABOLIC INSTITUTE
PERSONAL INFORMATION QUESTIONNAIRE
(adapted from the WALI, Wadden and Foster, 2001 & Healing the Hungry Self, D. Price 1996)

IDENTIFYING INFORMATION

Name: ________________________________ Birth Sex: ❑ M ❑ F Age: _____ Birthdate: _____ / _____ / _____

How would you describe your gender? ____________________ What are your Pronouns? ________________________

Address: ___________________________________ Home Phone: (_____) __________________________

___________________________________ Work Phone: (_____) __________________________

Mobile Phone: (_____) __________________________

Ethnicity: ❑ Native American ❑ Asian ❑ African-American/Black ❑ Hispanic ❑ White
❑ Other: ____________________

WEIGHT HISTORY

Your present weight: _______ Your present height: ______

Your ideal weight: _______ When is the last time you weighed your ideal weight? ______________________

What is specifically motivating you to lose weight now? ____

____

What makes this a good time in your life to lose weight? ____

____

____

Please check the sentence below that best describes you:

- ❑ I definitely will not be able to devote 30 minutes daily to weight control
- ❑ I'm not sure if I can find 30 minutes daily for weight control.
- ❑ I can definitely find 30 minutes daily for weight control.
- ❑ I can devote more than 30 minutes daily to weight control.

Rate how confident you are that you will be able to significantly change your eating and exercise habits. Pick a number from 1 to 10 which 1 = "not at all confident" and 10 = "extremely confident." Your number is _____

At what age were you first overweight by 10 pounds or more? _____ yrs old

What has been your highest weight after age 21? _____ lbs at _____ yrs old

What has been your lowest weight (not due to illness) that you have weighed after age 21? _____ lbs at _____ yrs old, maintained for _____ yrs.

018a

PT.

MR.#/RM.

DR.

Was this weight reached through a weight loss effort? ❑ Yes ❑ No
If yes, how did you reach this weight?

____

____

Do you ever, or have you ever tried to lose weight by:

Making yourself vomit	❑ Yes	❑ No
Using water pills (diuretics)	❑ Yes	❑ No
Using laxatives	❑ Yes	❑ No
Going on very restrictive diets	❑ Yes	❑ No
Strenuous exercising	❑ Yes	❑ No
Fasting	❑ Yes	❑ No

Check the statement that best describes you: “During the past 6 months my weight has..”

❑ Decreased more than 10 pounds
❑ Decreased 5 – 10 pounds
❑ Been relatively stable
❑ Increased by 5-10 pounds
❑ Increased by 10 pounds or more

What was your weight:
6 months ago: _____ lbs
1 year ago: _____ lbs
2 years ago: _____ lbs

What has triggered weight gain after previous losses?

____

____

____

Describe your present weight:

❑ Very Overweight ❑ Slightly Overweight ❑ Average Weight

How do you feel about the way you look at your present weight:

❑ Satisfied ❑ Neutral ❑ Dissatisfied ❑ Very Dissatisfied

How does your present weight effect your daily activities:

❑ No effect ❑ Some Effect ❑ Often Interferes ❑ Extreme Effect

Describe:

____

____

____

PT.

MR.#/RM.

DR.

EATING BEHAVIORS

Do you ever feel that your eating pattern is abnormal or unusual compared to other people, either in amount eaten or rate of eating?

❑ Yes ❑ No ❑ Unsure

Do you ever eat large amounts of food quickly in a short amount of time? ❑ Yes ❑ No

Do you ever eat large quantities of food deliberately out of the sight of other people? ❑ Yes ❑ No

Do you ever plan bouts of overeating? ❑ Yes ❑ No

Do you ever have episodes of overeating that you would refer to as binges? ❑ Yes ❑ No

If yes what kind of food would you eat in an episode of overeating:

____

How much of this food would you eat in an episode of overeating:

____

How frequently do episodes like this tend to occur:

____

Which types of food are particularly troublesome/tempting (e.g., sweets, starches, etc):

____

Do you ever eat large amounts of food and stop only because of:

Abdominal or stomach pain ❑ Yes ❑ No
Someone is present or watching ❑ Yes ❑ No
Because you fall asleep ❑ Yes ❑ No

Do you ever feel out of control while you are eating or have the fear that you will not be able to stop eating?

❑ Yes ❑ No

Do you ever feel ashamed, guilty, blue, or disgusted with yourself after eating a large amount of food?

❑ Yes ❑ No

PT.

MR.#/RM.

DR.

Weight Loss Attempts: Make a list of the diets, medications, and/or other measures you have tried to reduce your weight, how old you were when you tried them, when you tried each one, how much weight you lost, the length of time the weight stayed off, and how much weight you gained back.

Weight Loss Effort	Age	Start and Stop Date	Pounds Lost	Time Kept Off	Weight Regained

LIFESTYLE BEHAVIORS

How physically active are you?

❑ Active ❑ Average ❑ Inactive

What do you do for physical activity, how often, and for how long at a time?

Activity	Frequency	Duration
____________	____________	____________
____________	____________	____________
____________	____________	____________

PT.

MR.#/RM.

DR.

McLAREN FLINT

McLAREN BARIATRIC AND METABOLIC INSTITUTE

PERSONAL INFORMATION QUESTIONNAIRE

Please indicate the degree to which you believe each of the following behaviors causes you to gain weight. In answering these questions, please use the 5-point scale below. Pick the one number that best describes how much the behavior contributes to your increased weight:

1 = Does not contribute at all
2 = Contributes a small amount
3 = Contributes a moderate amount
4 = Contributes a large amount
5 = Contributes the greatest amount

____ Eating too much food
____ Overeating at breakfast
____ Overeating at lunch
____ Overeating at dinner
____ Snacking between meals
____ Snacking after dinner
____ Eating because I feel physically hungry
____ Eating because I crave certain foods
____ Continuing to eat because I don't feel full after a meal
____ Eating because I can't stop once I've begun
____ Eating because of the good taste of food
____ Eating in response to the sight/smell of food

____ Eating while cooking food
____ Eating when anxious
____ Eating when tired
____ Eating when bored
____ Eating when stressed
____ Eating when angry
____ Eating when depressed
____ Eating when celebrating
____ Eating when happy
____ Eating with family/friends
____ Eating at business functions

Who prepares meals in your home? ____

Who does the grocery shopping in your home? ____

MEDICAL HISTORY

Who is your current primary care provider (doctor)? ____

Address: ____

Telephone: ____

When did you last have a complete physical examination? _____ / _____ / _____

Please indicate if you have had or have any of the medical conditions listed below:

Heart disease..❑ Yes ❑ No
Angina (chest pains) ....❑ Yes ❑ No
Stroke..❑ Yes ❑ No
High Blood Pressure ....❑ Yes ❑ No
Back Problems ....❑ Yes ❑ No
Arthritis..❑ Yes ❑ No
Gout ....❑ Yes ❑ No
Gallbladder disease ....❑ Yes ❑ No
Thyroid problems...................................❑ Yes ❑ No
Diabetes (Type I or II).............................❑ Yes ❑ No
Sleep Apnea...❑ Yes ❑ No
Other: ______________________________ ❑ Yes ❑ No

PT.

MR.#/RM.

DR.

McLAREN FLINT
McLAREN BARIATRIC AND METABOLIC INSTITUTE
PERSONAL INFORMATION QUESTIONNAIRE

List all medications (including any over the counter, herbal, natural) that you take regularly and for what:

MEDICATION	PRESCRIBED/TAKEN FOR
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

List any medication, drugs, or foods that you are allergic to:

____

List any hospitalizations or operations. Indicate your age at each hospital admission:

____

____

Do you see any of your medical problems as being complicated by your weight? Which ones? ___________________

____

____

SUBSTANCE USE

Do you smoke or vape currently? ❑ Yes ❑ No

If you smoke, how many cigarettes do you smoke a day: _____

How many years have you smoked: _____

Have you smoked or vaped in the past? ❑ Yes ❑ No

When did you quit: _____ / _____ / _____

How many cigarettes did you smoke? ___________________

Did you gain weight after quitting? _____

During the past year:

How many glasses of wine did you drink a week _____

How many bottles of beer did you drink a week _____

How many mixed drinks or liqueurs did you have a week _____

Have you ever tried to quit drinking: ❑ Yes ❑ No

When: _____ / _____ / _____ How long: ___________________

Do you use any recreational drugs currently: ❑ Yes ❑ No

Have you used any recreational drugs in the past: ❑ Yes ❑ No

Have you ever tried to quit using recreational drugs: ❑ Yes ❑ No

When: _____ / _____ / _____

PT.

MR.#/RM.

DR.

McLAREN FLINT
McLAREN BARIATRIC AND METABOLIC INSTITUTE
PERSONAL INFORMATION QUESTIONNAIRE

Have you ever been through substance abuse treatment for drugs or alcohol? ❑ Yes ❑ No

When: ____

MENTAL HEALTH HISTORY

List any counseling services that you have received which may include individual, group, or marital therapy

Reason for Contact	Counselor/Therapist	# of Sessions	Dates

Are you currently, or have you ever been under the care of a psychiatrist, or treated for depression or anxiety by your family doctor? ❑ Yes ❑ No

If yes, who, when, diagnosis, and medications:

____

Have you ever been hospitalized for psychiatric reasons? ❑ Yes ❑ No

PSYCHOSOCIAL INFORMATION

Who lives at home with you: ____

Present Marital Status: ❑ Single ❑ Married ❑ Cohabitate ❑ Separated ❑ Engaged ❑ Divorced ❑ Widowed

Please answer the following questions about each significant relationship:

Dates of relationship	Dates of termination	Reason (divorce, death)	Number of Children

If you are currently in a significant relationship, please answer the following questions:

Partner's Age: _____ Weight: _____ Height: _____

Partner's Occupation: __________________________ Place of Employment: __________________________

How long employed: ____________

Describe your partner's weight: ❑ Overweight ❑ Average ❑ Underweight

Is he/she/they partner supportive of you pursuing a weight management program at this time? ❑ Yes ❑ No

How does he/she demonstrate support for you? ____

____

PT.

MR.#/RM.

DR.

McLAREN FLINT

McLAREN BARIATRIC AND METABOLIC INSTITUTE

PERSONAL INFORMATION QUESTIONNAIRE

List your children/step children's ages, sex, height, weight and check off whether they are overweight, average, underweight. Include any children from previous relationships, whether they are living with you or not:

Age	Sex	Weight	Height	Overweight	Average	Underweight
______	______	______	______	❑	❑	❑
______	______	______	______	❑	❑	❑
______	______	______	______	❑	❑	❑
______	______	______	______	❑	❑	❑
______	______	______	______	❑	❑	❑

Is your father living? ❑ Yes Age _______
❑ No Age at, and cause of, death: ______________________________
Medical History: ______________________________
Occupation: ______________________________

Is your mother living? ❑ Yes Age _______
❑ No Age at, and cause of, death: ______________________________
Medical History: ______________________________
Occupation: ______________________________

Describe your parent's weights while you were growing up (check one for each):

	Overweight	Average	Underweight
Father	❑	❑	❑
Mother	❑	❑	❑

Describe your parent's current weight or weight throughout your adulthood:

	Overweight	Average	Underweight
Father	❑	❑	❑
Mother	❑	❑	❑

List your brother's and sister's age, birth sex, present weight, height, and check off whether they are overweight, average, or underweight:

Age	Sex	Weight	Height	Overweight	Average	Underweight
______	______	______	______	❑	❑	❑
______	______	______	______	❑	❑	❑
______	______	______	______	❑	❑	❑
______	______	______	______	❑	❑	❑
______	______	______	______	❑	❑	❑

What is your current occupation? ______________________________

What is your current place of employment? ______________________________

How long have you worked here? ______________________________

PT.

MR.#/RM.

DR.

McLAREN FLINT
McLAREN BARIATRIC AND METABOLIC INSTITUTE
PERSONAL INFORMATION QUESTIONNAIRE

Are you not working due to any disability: ❑ Yes ❑ No

What is the disability: ____________________

Circle the last year of school attended:

Grade School	High School	College
1 2 3 4 5 6 7 8	9 10 11 12	1 2 3 4 Associate's Bachelor's Masters PhD

Did you ever repeat any grades in elementary or high school? ❑ Yes ❑ No

If yes, which grade(s) ____________

Ever receive special education services: ❑ Yes ❑ No Describe: ____________________

____

____

Please indicate if you are currently experiencing any stress in your life related to the following events. Complete each item by checking the appropriate box:

Work:	❑ Yes	❑ No
Health:	❑ Yes	❑ No
Relationship with spouse/significant other:	❑ Yes	❑ No
Activities related to your children:	❑ Yes	❑ No
Activities related to your parents:	❑ Yes	❑ No
Legal/financial trouble:	❑ Yes	❑ No
School:	❑ Yes	❑ No
Moving:	❑ Yes	❑ No
Other: ____________	❑ Yes	❑ No

Are you planning any major life changes (e.g. new job, moving, relationship, etc.) during the next 6 months?

❑ Yes ❑ No

If yes, please briefly describe below:

____

____

____

____

PT.

MR.#/RM.

DR.