

NAME/ID:

DATE:

Current Weight: _____ kg lbs Date checked: _____ n/a

Height: _____ feet/inches cm

*Body Mass Index (BMI): _____ *To be calculated by clinician

Blood Pressure: _____/_____ mmHg Date checked: _____ n/a

Fasting Glucose: _____ mmol/L mg/dl Date checked: _____ n/a

HbA1c: _____ % Date checked: _____ n/a

We are interested in your own beliefs about your weight. We are NOT interested in what others believe or may wish you to believe.

Indicate if you have any of the following health related experiences by reading the questions and marking either Yes or No.

	Yes	No
A) Do you regularly have trouble breathing, particularly with movement (i.e. walking, running, climbing stairs, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
B) Do you regularly have trouble sleeping at night?	<input type="checkbox"/>	<input type="checkbox"/>
C) Do you regularly wake up gasping for air?	<input type="checkbox"/>	<input type="checkbox"/>
D) Are you regularly fatigued?	<input type="checkbox"/>	<input type="checkbox"/>
E) Do you regularly feel down or depressed?	<input type="checkbox"/>	<input type="checkbox"/>
F) Do you avoid being around other people?	<input type="checkbox"/>	<input type="checkbox"/>
G) Do you regularly have aches and pains?	<input type="checkbox"/>	<input type="checkbox"/>
H) Do you frequently have chest pain, particularly with movement (i.e. walking, running, climbing stairs, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
I) Do you sometimes lose control of your bladder?	<input type="checkbox"/>	<input type="checkbox"/>
J) Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

If 'NO' to ALL of the above, please go to the next page.

If 'YES' to any of the above, indicate the extent to which you agree or disagree at the present moment with the following statement by circling the appropriate number, keeping in mind your health related experiences.

1) My experiences are due to being overweight or obese.

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Strongly Disagree

Moderately Disagree

Slightly Disagree

Unsure

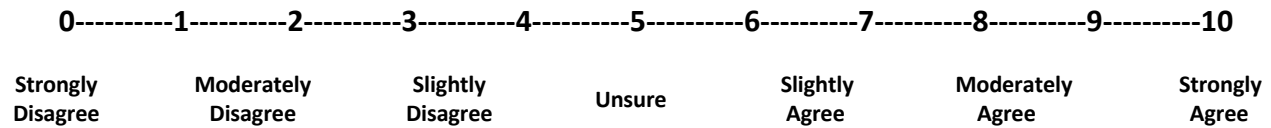
Slightly Agree

Moderately Agree

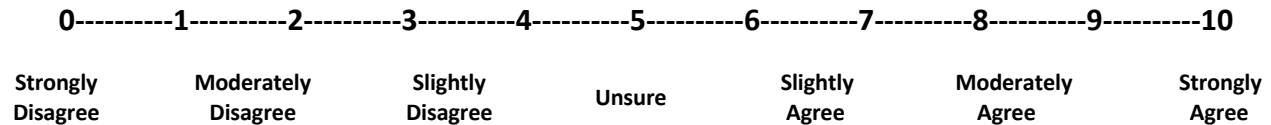
Strongly Agree

Please indicate the extent to which you agree or disagree at the present moment with each of the following statements by circling the appropriate number.

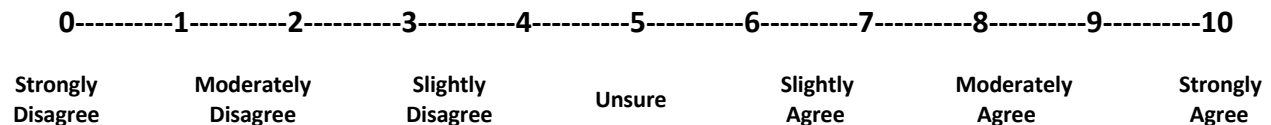
2) I have an excessive amount of body fat.



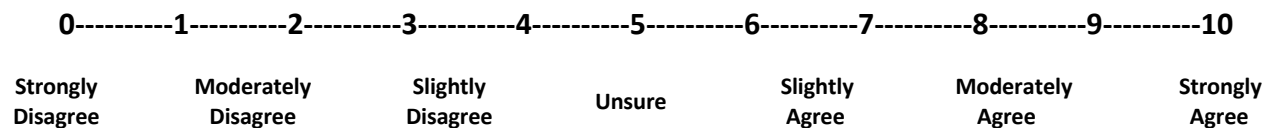
3) I NEED to make or maintain healthy life style changes to improve my diet and/or adjust the amount I exercise.



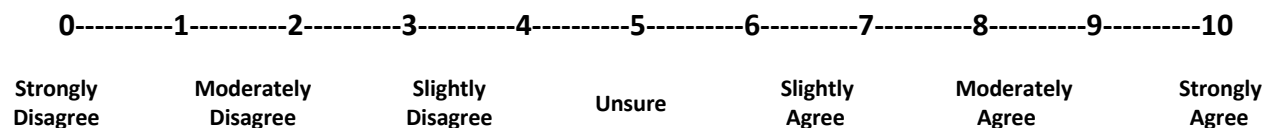
4) I am at a healthy weight.



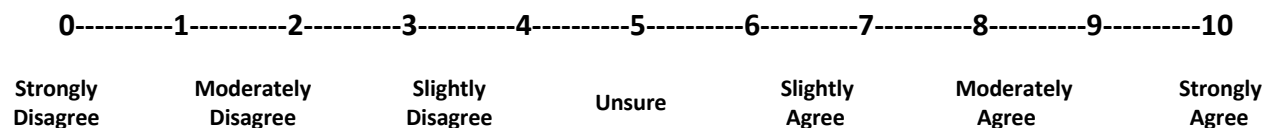
5) I can safely carry on my current lifestyle (i.e. eating and exercising as I currently do).



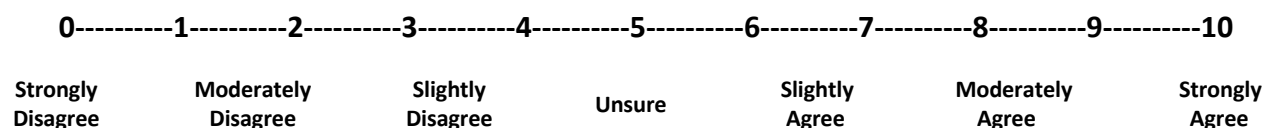
6) My weight has led or can lead to negative health consequences (e.g. high cholesterol, hypertension, diabetes, heart disease, depression, etc.).



7) I am overweight or have obesity (i.e. Body Mass Index greater than 25 = overweight; Body Mass Index greater than 30 = obese).



8) I need weight loss treatment.



THE END