Weight Questionnaire for Adolescents

SYMPTOMS:

Do you have any of the following symptoms?	No	Yes
Feeling cold	❑	❑
Cold or blue hands or feet	❑	❑
Constipation	❑	❑
Problems with dry skin	❑	❑
Problems with dry hair or hair falling out	❑	❑
Dizziness	❑	❑
Fainting	❑	❑
Headaches	❑	❑
Feeling tired	❑	❑
Feeling weak	❑	❑
Feeling full after eating small amounts of food	❑	❑
Loss of appetite	❑	❑
Difficulty concentrating	❑	❑
Difficulty making decisions	❑	❑
Being irritable	❑	❑
Being sad or bored	❑	❑
Not wanting to be around friends	❑	❑
Not wanting to be around family	❑	❑
Thinking about food	❑	❑
Worrying about gaining weight	❑	❑
Loss or irregularity of menstrual periods (females)	❑	❑

WEIGHT AND ACTIVITY HISTORY

What is the most you have ever weighed? ____________

What is the least you have weighed in the last year? ____________

What do you weigh now? ____________

What would you like to weigh? ____________

Are you trying to lose weigh? ❑ **No** ❑ **Yes**

How often do you weigh yourself? ____________

Do you exercise at least once a week? ❑ **No** ❑ If **Yes**, check all that apply

	No	Yes	Hours/Week
Running/jogging	❑	❑	____________
Aerobics/calisthenics	❑	❑	____________
Dancing/ballet	❑	❑	____________
Gymnastics	❑	❑	____________
Swimming	❑	❑	____________
Team sport(s)	❑	❑	____________
Other:			

Do you exercise to lose weight? ❑ **No** ❑ **Yes**

Check all the methods that you have used to try to control your weight.

Ever:	❑ Dieting	❑ Exercising	❑ Diet Pills	❑ Vomiting	❑ Laxatives
In the last two months:	❑ Dieting	❑ Exercising	❑ Diet Pills	❑ Vomiting	❑ Laxatives

Office on Women's Health

SOURCE *Publication: Questionnaire from ADOLESCENT MEDICINE: STATE OF THE ART REVIEWS (now called Adolescent Medicine Clinics), V14(1): 138-139, Kreipe, R., Yussman, S.M.: "The role of the primary care practitioner in the treatment of eating disorders." © 2003 Elsevier Inc.*

EATING HISTORY

Rate on a scale of 0 to 5 how much you eat at each of the following times in a typical day.

Nothing = 0 ***Snack = 1*** ***Small meal = 2*** ***Meal = 3*** ***Large meal = 4*** ***Binge = 5***

At		***Between***		***After***	
Breakfast	________	Breakfast and lunch	________	Going to bed	________
Lunch	________	Lunch and dinner	________	Something upsetting	________
Dinner	________	Dinner and bedtime	________		

Please describe your typical breakfast, lunch, dinner and snack.

	Food/Beverage	***Amount***
Breakfast	________	________
	________	________
	________	________
	________	________
Lunch	________	________
	________	________
	________	________
	________	________
Dinner	________	________
	________	________
	________	________
	________	________
Snack	________	________
	________	________
	________	________
	________	________

FAMILY HISTORY:

Are there any family members with the following conditions (include aunts/uncles, cousins, grandparents, as well as immediate family)?

	No	**Yes**
Alcohol and drug use	❑	❑
Anorexia nervosa	❑	❑
Asthma	❑	❑
Bulimia (binge eating)	❑	❑
Cancer	❑	❑
Colitis	❑	❑
Depression	❑	❑
Diabetes (high sugar)	❑	❑
Mental illness	❑	❑
Obesity	❑	❑
Thyroid disease	❑	❑
Ulcers	❑	❑
Vomiting	❑	❑
Other	❑	❑

Please explain any yes answers: ____

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