



Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone # \_\_\_\_\_ Email: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: \_\_\_\_\_

**PLEASE FAX OR MAIL BACK PRIOR TO FIRST APPOINTMENT. FAX 203.569.4964**

**LIVING SITUATION**

- \_\_\_\_\_ ALONE
- \_\_\_\_\_ ROOMMATE(S)
- \_\_\_\_\_ SPOUSE
- \_\_\_\_\_ PARTNER
- \_\_\_\_\_ PARENTS
- \_\_\_\_\_ DORMITORY
- \_\_\_\_\_ APARTMENT
- \_\_\_\_\_ ROOM IN A HOUSE
- \_\_\_\_\_ OTHER: SPECIFY \_\_\_\_\_

**REFERRING PERSON/AGENCY**

- \_\_\_\_\_ UNIVERSITY HEALTH SERVICES CLINICIAN
- \_\_\_\_\_ OTHER CLINICIAN
- \_\_\_\_\_ OTHER PSYCHOLOGIST
- \_\_\_\_\_ TRAINER/COACH/FACULTY/RA
- \_\_\_\_\_ SELF
- \_\_\_\_\_ OTHER

PLEASE SPECIFY NAME OF REFERRING PERSON(S): \_\_\_\_\_

**CLASS SCHEDULE**

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
8:00					
9:00					
10:00					
11:00					
12:00					
1:00					
2:00					
3:00					
4:00					
5:00					

**MEDICAL HISTORY**

- |                                    |                                     |
|------------------------------------|-------------------------------------|
| _____ Alcohol and other drug abuse | _____ High Cholesterol              |
| _____ Allergies                    | _____ High Triglyceride             |
| _____ Anemia                       | _____ Kidney Disease                |
| _____ Anorexia or Bulimia          | _____ Liver Disease                 |
| _____ Arthritis                    | _____ Lung Disease                  |
| _____ Cancer                       | _____ Stomach or GI problems        |
| _____ Diabetes                     | _____ Thyroid Disease               |
| _____ Gout                         | _____ Vision Problems (not glasses) |
| _____ Hearing Problems             | _____ Weight Problems               |
| _____ Heart Disease                | _____ Depression                    |
| _____ High Blood Pressure          | _____ Date of Last Menstrual Cycle  |

**Has anyone in your family had any of the following problems? (please check and list family member)**

- \_\_\_\_\_ Arthritis \_\_\_\_\_
- \_\_\_\_\_ Cancer \_\_\_\_\_
- \_\_\_\_\_ Diabetes \_\_\_\_\_
- \_\_\_\_\_ Heart Disease or Stroke \_\_\_\_\_
- \_\_\_\_\_ High Blood Pressure \_\_\_\_\_
- \_\_\_\_\_ High Cholesterol \_\_\_\_\_
- \_\_\_\_\_ High Triglyceride \_\_\_\_\_
- \_\_\_\_\_ Smoke Cigarettes \_\_\_\_\_ pack/day \_\_\_\_\_
- \_\_\_\_\_ Weight Problems \_\_\_\_\_
- \_\_\_\_\_ Depression \_\_\_\_\_
- \_\_\_\_\_ Osteoporosis \_\_\_\_\_
- \_\_\_\_\_ Other \_\_\_\_\_

**MEDICATIONS PRESCRIBED BY A DOCTOR:**

Prescription	Dose
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**PLEASE LIST ANY OVER THE COUNTER MEDICINES YOU ARE TAKING, E.G., DIET PILLS, WATER PILLS, LAXATIVES, ETC.**

Name	How Often
_____	_____
_____	_____
_____	_____
_____	_____

**PLEASE LIST ANY SUPPLEMENTS THAT YOU ARE CURRENTLY TAKING:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**PLEASE CIRCLE THE FOLLOWING ANSWER:**

---

I eat sweets & carbohydrates without feeling nervous

Always

Usually

Often

Sometimes

Rarely

Never

---

I think about dieting

Always

Usually

Often

Sometimes

Rarely

Never

---

I feel extremely guilty after overeating

Always

Usually

Often

Sometimes

Rarely

Never

---

I am terrified of gaining weight

Always

Usually

Often

Sometimes

Rarely

Never

---

I exaggerate or magnify the importance of my weight

Always

Usually

Often

Sometimes

Rarely

Never

---

I am preoccupied with a desire to be thinner

Always

Usually

Often

Sometimes

Rarely

Never

---

If I gain a pound, I worry that I will keep gaining

Always

Usually

Often

Sometimes

Rarely

Never

---

# EATING HABITS INVENTORY

Directions: Complete each question and when appropriate check as many responses as are applicable. Remember, there are no right or wrong answers!

## 1. I eat when I am:

- |  |                                    |                                   |                                      |
|--|------------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Happy           | <input type="checkbox"/> Bored     | <input type="checkbox"/> Lonely   | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Depressed       | <input type="checkbox"/> Excited   | <input type="checkbox"/> Stressed | _____                                |
| <input type="checkbox"/> Nervous         | <input type="checkbox"/> Tired     | <input type="checkbox"/> Tired    | _____                                |
| <input type="checkbox"/> All of the time | <input type="checkbox"/> Near food | <input type="checkbox"/> Worried  | _____                                |
| <input type="checkbox"/> Hungry          | <input type="checkbox"/> Sad       | <input type="checkbox"/> In Love  | _____                                |
| <input type="checkbox"/> Scared          | <input type="checkbox"/> Angry     | <input type="checkbox"/> Busy     | _____                                |

2. When I eat I usually feel: \_\_\_\_\_  
\_\_\_\_\_

3. When I don't eat I usually feel: \_\_\_\_\_  
\_\_\_\_\_

4. It usually take me (how many) minutes to eat: Breakfast \_\_\_\_\_  
Lunch \_\_\_\_\_  
Dinner \_\_\_\_\_  
Snacks \_\_\_\_\_

5. I usually eat \_\_\_\_\_ times a day.  
I usually eat according to:

<input type="checkbox"/> Time of day	<input type="checkbox"/> Hunger
<input type="checkbox"/> My schedule	<input type="checkbox"/> Other _____
<input type="checkbox"/> Emotions	_____

## 6. I usually eat my meals or snacks when I am:

- |                                      |   |  |
|--------------------------------------|---|--|
| <input type="checkbox"/> Working     | <input type="checkbox"/> Baby-sitting         | <input type="checkbox"/> Socializing   |
| <input type="checkbox"/> Driving     | <input type="checkbox"/> Shopping             | <input type="checkbox"/> Making a meal |
| <input type="checkbox"/> Watching TV | <input type="checkbox"/> Walking              | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> Studying    | <input type="checkbox"/> Entertaining         | _____                                  |
| <input type="checkbox"/> Reading     | <input type="checkbox"/> With friends         |  |
| <input type="checkbox"/> Alone       | <input type="checkbox"/> Talking on the phone |  |

(body position):  Sitting  
 Lying down  
 Standing  
 Other \_\_\_\_\_

7. I usually plan what I eat at the next meal or snack \_\_\_\_\_  
minutes/hours/days in advance. (describe) \_\_\_\_\_  
\_\_\_\_\_

8. I spend \_\_\_\_\_% of the day thinking about food.

9. When I have a “bad” day, emotionally, my food choices are:

---

---

10. When I have a “good” day, emotionally, food choices are:

---

---

11. When I overeat I usually feel (describe):

---

---

12. My “safe” foods are:

---

---

13. My “scary” foods are:

---

---

14. I remember the following about food: \_\_\_\_\_  
When I was a child my favorite foods were: \_\_\_\_\_

15. I enjoy cooking  yes  no  sometimes

16. When I shop for food I usually:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> am in a hurry                                 | <input type="checkbox"/> am binging              | <input type="checkbox"/> am hungry        |
| <input type="checkbox"/> bring a list                                  | <input type="checkbox"/> don't bring a list      | <input type="checkbox"/> shop for the day |
| <input type="checkbox"/> shop for the week                             | <input type="checkbox"/> shop for others(#_____) |   |
| <input type="checkbox"/> eat something on the way home                 |  |   |
| <input type="checkbox"/> eat something when I get home                 |  |   |
| <input type="checkbox"/> I don't do the food shopping. Who does? _____ |  |   |

17. I had the following for dinner last night:

---

---

---

18. I usually  eat to live  live to eat

19. I  enjoy eating  don't enjoy eating