

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Informed Consent

1 Did participant present for baseline visit?

- ₀ No → If No: Specify reason (check only one):
- ₁ Failed an eligibility criterion (participant no longer meets criteria)
 - ₂ Lost interest in the study
 - ₃ Will take too much time
 - ₄ Scheduling conflicts with work or school
 - ₅ Doesn't like the study's procedures
 - ₆ Doesn't want to be involved in a research study
 - ₇ Unwilling to be randomized
 - ₈ Lives too far away/transportation problems
 - ₉ Needs help with child care (unanticipated child care needs)
 - ₁₀ Refused with no explanation
 - ₁₁ Unable to contact
 - ₉₈ Other (specify): _____
- ₁ Yes

2 Date and time study baseline informed consent signed: ____/____/____ :____

day month year 00:00 to 23:59

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Informed Consent Detail

Tissue consent:

Sample type	Check only one		
	Participant consent given for future studies by Calerie and external investigators	Participant consent given for future studies by Calerie	Participant consent not given
1 Blood archive	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2 Urine archive	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3 Muscle biopsy archive	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
4 Fat biopsy archive	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Clinic Weight

Weight date and time: _____ / _____ / _____ : _____
day month year 00:00 to 23:59

Staff initials: _____
first middle last

OR Not done → Specify reason (use Codelist below): _____

Clinic weight (if the first two measurements are more than 0.1 kg apart, measure weight a third time):

Weight 1: _____ . _____ kg

Weight 2: _____ . _____ kg

Weight 3: _____ . _____ kg

Weight of gown: _____ . _____ kg

Vital Signs

Assessment date and time: _____ / _____ / _____ : _____
day month year 00:00 to 23:59

If waist measurement not done → Specify reason (use codelist below): _____

1 Natural waist measurement

(if the first two measurements are more than 1.0 cm apart, measure natural waist circumference a third time):

Staff initials: _____
first middle last

Natural waist measurement 1: _____ . _____ cm

Natural waist measurement 2: _____ . _____ cm

Natural waist measurement 3: _____ . _____ cm

2 Umbilical point waist measurement (if the first two measurements are more than 1.0 cm apart, measure umbilical point waist circumference a third time):

Umbilical point waist measurement 1: _____ . _____ cm

Umbilical point waist measurement 2: _____ . _____ cm

Umbilical point waist measurement 3: _____ . _____ cm

3 Pulse: _____ bpm OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

4 Temperature: _____ . _____ °C OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

5 Respirations: _____ per minute OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

6 Blood pressure (check only one): ₁ Left arm ₂ Right arm

Staff initials: _____
first middle last

6a Blood pressure 1: _____ / _____ mm Hg Time: _____ : _____
systolic diastolic 00:00 to 23:59 OR Not done →
 Specify reason (use codelist below): _____

6b Blood pressure 2: _____ / _____ mm Hg Time: _____ : _____
systolic diastolic 00:00 to 23:59

6c Blood pressure 3: _____ / _____ mm Hg Time: _____ : _____
systolic diastolic 00:00 to 23:59

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Center Number: _____ Participant Number: _____ Participant's Initials: _____
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12-Lead ECG

Date and Time	Findings	Staff Initials
<p>____/____/____ 00:00 to 23:59 <small>day month year</small></p> <p>OR Not done → Specify reason (see codelist below): _____</p>	<p>Is ECG (check only one):</p> <p><input type="checkbox"/>₁ Normal</p> <p><input type="checkbox"/>₂ Abnormal, not clinically significant (specify): _____</p> <p><input type="checkbox"/>₃ Abnormal, clinically significant (specify): _____</p>	<p>_____ <small>first middle last</small></p>

Safety Labs

Date and time of last meal: ____/____/____ 00:00 to 23:59
day month year

Date and time of sample collection: ____/____/____ 00:00 to 23:59
day month year

Sample	Sample Complete?	If Not Done, Reason (Use codelist below)	Staff Initials
Blood	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	_____ <small>first middle last</small>
Urine	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	_____ <small>first middle last</small>

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Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Date completed: ____/____/____
day month year

Abbreviated Medical History

List any clinically significant changes occurring since Screening medical history was completed.

Body System	Assessments		
	No Change	Yes	If Yes, Specify Diagnosis
1 Head, Ears, Eyes, Nose, Throat	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
2 Dermatologic	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
3 Cardiovascular	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
4 Respiratory	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
5 Gastrointestinal	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
6 Endocrine/Metabolic	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
7 Genitourinary	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
8 Neurological	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
9 Blood/Lymphatic	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
10 Musculoskeletal	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
11 Hepatic	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
12 Drug Allergies	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
13 Other Allergies	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
14 Psychological/Psychiatric	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
15 Other	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	

Physician's Signature

Signature: _____ Date: ____/____/____
day month year

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Physical Examination

Date of examination: ____/____/____
day month year

Staff initials: _____
first middle last

OR Not done → Specify reason (use codelist below): _____

Body System	Assessments			If Abnormal or Not Done: Explain
	Normal	Abnormal	Not Done	
1 General appearance:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
2 Head, Ears, Eyes, Nose, Throat:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
3 Neck:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
4 Heart:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
5 Lungs:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
6 Abdomen:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
7 Lymph nodes:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
8 Extremities/Skin:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
9 Neurological:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
10 Musculoskeletal:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
	Normal	Abnormal	Not Done *	
11 Genitourinary:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
12 Breast:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	

Physician's Signature

Investigator: _____
signature

Date: ____/____/____
day month year

* Not done at this examination OR Referred participant to primary care physician for exam.

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first middle last

Clinic Weight

Weight date and time: ____/____/____ : ____
day month year 00:00 to 23:59

Staff initials:
first middle last

OR Not done → Specify reason (use codelist below): ____

Clinic weight (if the two measurements are more than 0.1 kg apart, measure weight a third time):

Weight 1: _____ . ____ kg

Weight 2: _____ . ____ kg

Weight 3: _____ . ____ kg

Weight of gown: _____ . ____ kg

Pregnancy Test

Complete only for females.

Does participant have reproductive potential?

₀ No

₁ Yes → If Yes: Date urine pregnancy test performed: ____/____/____
day month year

Results: ₁ Negative

₂ Positive

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Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Doubly Labeled Water (DLW)

1 Date and time of DLW dosing: _____ / _____ / _____ : _____
day month year 00:00 to 23:59 Staff initials: _____
first middle last

OR Not done → Specify reason (use codelist below): _____

2 DLW dose mixture ID and bottle number: _____ - _____ - _____ - CA

3 Exact weight of DLW mixture: _____ . _____ grams

4 Urine samples:

Collection	Sample	Date and Time Collected
Pre dosing (PD)	PDa	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
	PDb	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
Day 0 (Visit 2)	D0a	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
	D0b	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
Day 7 (Visit 3)	D7a	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
	D7b	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
Day 14 (Visit 4)	D14a	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
	D14b	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>

5 Affix CRF page label(s) corresponding to this urine sample set:

Affix
Label
Here

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DXA Scan

1 Has the participant taken a calcium supplement today?

₀ No ₁ Yes → If Yes: Proceed with scan and document in the Subject Scan Log to inform the QA Center.

2 Were any studies involving barium or radioisotopes performed within 4 weeks prior to the scheduled DXA exam?

₀ No ₁ Yes

DXA Scan		DXA Rescan OR <input type="checkbox"/> ₉₆ NA
Date of scan: ____/____/____ <small>day month year</small>		Date of rescan: ____/____/____ <small>day month year</small>
Area Scanned Check all that apply	If Not Done, Reason (Use codelist below)	Area Scanned Check all that apply
<input type="checkbox"/> Whole body	_____	<input type="checkbox"/> Whole body
<input type="checkbox"/> Forearm	_____	<input type="checkbox"/> Forearm
<input type="checkbox"/> Spine	_____	<input type="checkbox"/> Spine
<input type="checkbox"/> Hip	_____	<input type="checkbox"/> Hip

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Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): _____
day month year

RAND SF-36

Instructions: This survey asks for your views about your health. This information will help keep track of how well you are able to do your usual activities. Please answer every question by placing a check "X" in the appropriate box. If you are unsure about how to answer a question, give the best answer you can.

1 In general, would you say your health is: ₁ Excellent ₂ Very good ₃ Good ₄ Fair ₅ Poor

2 Compared to one year ago, how would you rate your health in general now? ₁ Much better now than 1 year ago
₂ Somewhat better now than 1 year ago
₃ About the same
₄ Somewhat worse now than 1 year ago
₅ Much worse now than 1 year ago

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All
--	--------------------	-----------------------	------------------------

3 Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
---	---------------------------------------	---------------------------------------	---------------------------------------

4 Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

5 Lifting or carrying groceries	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

6 Climbing several flights of stairs	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
---	---------------------------------------	---------------------------------------	---------------------------------------

7 Climbing one flight of stairs	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

8 Bending, kneeling or stooping	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

9 Walking more than a mile	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
-----------------------------------	---------------------------------------	---------------------------------------	---------------------------------------

10 Walking several blocks	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
----------------------------------	---------------------------------------	---------------------------------------	---------------------------------------

11 Walking one block	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
-----------------------------	---------------------------------------	---------------------------------------	---------------------------------------

12 Bathing or dressing yourself	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

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first middle last

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Center Number: ____ Participant Number: ____ Participant's Initials: first middle last _____

Rand SF-36 (continued)

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

Yes **No**

13 Cut down on the **amount of time** you spent on work or other activities ₁ ₂

14 **Accomplished less** than you would like ₁ ₂

15 Were limited in the **kind** of work or other activities ₁ ₂

16 Had **difficulty** performing the work or other activities
(for example, it took extra effort) ₁ ₂

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)

Yes **No**

17 Cut down on the **amount of time** you spent on work or other activities ₁ ₂

18 **Accomplished less** than you would like ₁ ₂

19 Didn't do work or other activities as **carefully** as usual ₁ ₂

20 During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors or groups?

₁ Not at all
₂ Slightly
₃ Moderately
₄ Quite a bit
₅ Extremely

21 How much **bodily** pain have you had during the **past 4 weeks**?

₁ None
₂ Very mild
₃ Mild
₄ Moderate
₅ Severe
₆ Very severe

22 During the **past 4 weeks**, how much did pain interfere with your normal work (including both work outside the home and housework)?

₁ Not at all
₂ A little bit
₃ Moderately
₄ Quite a bit
₅ Extremely

Participant's Initials: first middle last _____

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last _____

RAND SF-36 (continued)

These questions are about how you feel and how things have been with you *during the past 4 weeks*. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the <i>past 4 weeks</i> ...	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
23 Did you feel full of pep?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
24 Have you been a very nervous person?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
25 Have you felt so down in the dumps that nothing could cheer you up?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
26 Have you felt calm and peaceful?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
27 Did you have a lot of energy?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
28 Have you felt downhearted and blue?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
29 Did you feel worn out?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
30 Have you been a happy person?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
31 Did you feel tired?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
32 During the <i>past 4 weeks</i> , how much of the time has your physical health or emotional problems interfered with your social activities (<i>like visiting friends, relatives, etc</i>)?	All of the Time	Most of the Time	Some of the Time	A Little of the Time	None of the Time	
	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	
How true or false is each of the following statements for you?	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False	
33 I seem to get sick a little easier than other people.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	
34 I am healthy as anybody I know.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	
35 I expect my health to get worse.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	
36 My health is excellent.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	

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Date: ____/____/____ OR Not done → Specify reason (use codelist below): ____
day month year

BDI-II

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Check the box beside the statement you have picked. Be sure that you check only one statement for each group, including item 16 and item 18.

- 1 Sadness:**
- ₀ I do not feel sad
 - ₁ I feel sad much of the time
 - ₂ I am sad all of the time
 - ₃ I am so sad or unhappy that I can't stand it
- 2 Pessimism:**
- ₀ I am not discouraged about my future
 - ₁ I feel more discouraged about my future than I used to be
 - ₂ I do not expect things to work out for me
 - ₃ I feel my future is hopeless and will only get worse
- 3 Past failure:**
- ₀ I do not feel like a failure
 - ₁ I have failed more than I should have
 - ₂ As I look back, I see a lot of failures
 - ₃ I feel I am a total failure as a person
- 4 Loss of pleasure:**
- ₀ I get as much pleasure as I ever did from the things I enjoy
 - ₁ I don't enjoy things as much as I used to
 - ₂ I get very little pleasure from the things I used to enjoy
 - ₃ I can't get any pleasure from the things I used to enjoy
- 5 Guilty feelings:**
- ₀ I don't feel particularly guilty
 - ₁ I feel guilty over many things I have done or should have done
 - ₂ I feel quite guilty most of the time
 - ₃ I feel guilty all of the time
- 6 Punishment feelings:**
- ₀ I don't feel I am being punished
 - ₁ I feel I may be punished
 - ₂ I expect to be punished
 - ₃ I feel I am being punished
- 7 Self-dislike:**
- ₀ I feel the same about myself as ever
 - ₁ I have lost confidence in myself
 - ₂ I am disappointed in myself
 - ₃ I dislike myself

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BDI-II (continued)

- 8 Self-criticalness:**
- ₀ I don't criticize or blame myself more than usual
 - ₁ I am more critical of myself than I used to be
 - ₂ I criticize myself for all of my faults
 - ₃ I blame myself for everything bad that happens
- 9 Suicidal thoughts or wishes:**
- ₀ I don't have any thoughts of killing myself
 - ₁ I have thoughts of killing myself but I would not carry them out
 - ₂ I would like to kill myself
 - ₃ I would kill myself if I had the chance
- 10 Crying:**
- ₀ I don't cry any more than I used to
 - ₁ I cry more than I used to
 - ₂ I cry over every little thing
 - ₃ I feel like crying, but I can't
- 11 Agitation:**
- ₀ I am no more wound up or restless than usual
 - ₁ I feel more restless or wound up than usual
 - ₂ I am so restless or agitated that it's hard to stay still
 - ₃ I am so restless or agitated that I have to keep moving or doing something
- 12 Loss of interest:**
- ₀ I have not lost interest in other people or activities
 - ₁ I am less interested in other people or things than before
 - ₂ I have lost most of my interest in other people or things
 - ₃ It's hard to get interested in anything
- 13 Indecisiveness:**
- ₀ I make decisions about as well as ever
 - ₁ I find it more difficult to make decisions than usual
 - ₂ I have much greater difficulty in making decisions than I used to
 - ₃ I have trouble making my decisions
- 14 Worthlessness:**
- ₀ I do not feel I am worthless
 - ₁ I don't consider myself as worthwhile and useful as I used to
 - ₂ I feel more worthless as compared to other people
 - ₃ I feel utterly worthless
- 15 Loss of energy:**
- ₀ I have as much energy as ever
 - ₁ I have less energy than I used to have
 - ₂ I don't have enough energy to do very much
 - ₃ I don't have enough energy to do anything

Participant's Initials:
first middle last

Center Number: ____ Participant Number: ____ Participant's Initials:
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BDI-II (continued)

- 16 Changes in sleeping pattern:**
- ₀ I have not experienced any change in my sleeping pattern
 - ₁ I sleep somewhat more than usual
 - ₂ I sleep somewhat less than usual
 - ₃ I sleep a lot more than usual
 - ₄ I sleep a lot less than usual
 - ₅ I sleep most of the day
 - ₆ I wake up 1-2 hours early and can't get back to sleep

- 17 Irritability:**
- ₀ I am no more irritable than usual
 - ₁ I am more irritable than usual
 - ₂ I am much more irritable than usual
 - ₃ I am irritable all of the time

- 18 Changes in appetite:**
- ₀ I have not experienced any change in my appetite
 - ₁ My appetite is somewhat less than usual
 - ₂ My appetite is somewhat greater than usual
 - ₃ My appetite is much less than before
 - ₄ My appetite is much greater than usual
 - ₅ I have no appetite at all
 - ₆ I crave food all of the time

- 19 Concentration difficulty:**
- ₀ I can concentrate as well as ever
 - ₁ I can't concentrate as well as usual
 - ₂ It's hard to keep my mind on anything for very long
 - ₃ I find I can't concentrate on anything

- 20 Tiredness or fatigue:**
- ₀ I am no more tired or fatigued than usual
 - ₁ I get more tired or fatigued more easily than usual
 - ₂ I am too tired or fatigued to do a lot of the things I used to do
 - ₃ I am too tired or fatigued to do most of the things I used to do

- 21 Loss of interest in sex:**
- ₀ I have not noticed any recent change in my interest in sex
 - ₁ I am less interested in sex than I used to be
 - ₂ I am much less interested in sex now
 - ₃ I have lost interest in sex completely

Participant's Initials:
first middle last

Center Number: ____ Participant Number: _____ Participant's Initials: _____
first middle last

Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): _____
day month year

Profile of Mood States

Instructions: Please describe **how you feel right now** by checking one box for each of the words listed below.

Feeling	Not At All	A Little	Moderately	Quite A Bit	Extremely
1 Friendly	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
2 Tense	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
3 Angry	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4 Worn out	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
5 Unhappy	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
6 Clear-headed	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
7 Lively	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
8 Confused	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
9 Sorry for things done	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
10 Shaky	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
11 Listless	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
12 Peeved	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
13 Considerate	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
14 Sad	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
15 Active	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
16 On edge	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
17 Grouchy	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
18 Blue	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
19 Energetic	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
20 Panicky	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

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Profile of Mood States (continued)

Feeling	Not At All	A Little	Moderately	Quite A Bit	Extremely
21 Hopeless	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
22 Relaxed	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
23 Unworthy	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
24 Spiteful	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
25 Sympathetic	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
26 Uneasy	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
27 Restless	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
28 Unable to concentrate	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
29 Fatigued	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
30 Helpful	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
31 Annoyed	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
32 Discouraged	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
33 Resentful	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
34 Nervous	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
35 Lonely	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
36 Miserable	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
37 Muddled	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
38 Cheerful	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
39 Bitter	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
40 Exhausted	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
41 Anxious	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
42 Ready to fight	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
43 Good-natured	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

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Profile of Mood States (continued)

Feeling	Not At All	A Little	Moderately	Quite A Bit	Extremely
44 Gloomy	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
45 Desperate	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
46 Sluggish	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
47 Rebellious	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
48 Helpless	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
49 Weary	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
50 Bewildered	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
51 Alert	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
52 Deceived	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
53 Furious	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
54 Efficient	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
55 Trusting	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
56 Full of pep	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
57 Bad-tempered	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
58 Worthless	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
59 Forgetful	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
60 Carefree	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
61 Terrified	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
62 Guilty	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
63 Vigorous	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
64 Uncertain about things	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
65 Bushed	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

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day month year

Perceived Stress Scale (PSS)

Instructions: The questions in this scale ask you about your feelings and thoughts during the last month. In each case, please indicate how often you felt or thought a certain way. Please check only one answer for each question.

	Never	Almost Never	Some- times	Fairly Often	Very Often
1 In the last month, how often have you felt that you were unable to control the important things in your life?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
2 In the last month, how often have you felt confident about your ability to handle your personal problems?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
3 In the last month, how often have you felt that things were going your way?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4 In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Participant's Initials: first middle last ____

Center Number: _____ Participant Number: _____ Participant's Initials: _____
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day month year

Pittsburgh Sleep Quality Index (PSQI)

Instructions: The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions.

During the past month...

1 When have you usually gone to bed? _____ : _____
00:00 to 23:59

2 How long (in minutes) has it taken you to fall asleep each night? _____ minutes

3 When have you usually gotten up in the morning? _____ : _____
00:00 to 23:59

4 How many hours of actual sleep did you get at night?
(This may be different than the number of hours you spend in bed.) ____ . ____ hours

5 During the past month, how often have you had trouble sleeping because you... (check only one answer per question)	Not during the past month	Less than once a week	Once or twice a week	3 or more times a week
a Cannot get to sleep within 30 minutes	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
b Wake up in the middle of the night or early morning	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
c Have to get up to use the bathroom	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
d Cannot breathe comfortably	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
e Cough or snore loudly	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
f Feel too cold	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
g Feel too hot	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
h Have bad dreams	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
i Have pain	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
j Other reason(s), please describe, including how often you have had trouble sleeping because of this reason(s): _____	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
6 During the past month, how often have you taken medicine (prescribed or "over the counter") to help you sleep?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

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Pittsburgh Sleep Quality Index (PSQI) (continued)

	Never	Once or twice	Once or twice each week	3 or more times each week
7 During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
	No problem at all	Only a very slight problem	Somewhat of a problem	A very big problem
8 During the past month, how much of a problem has it been for you to keep up enthusiasm to get things done?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
	Very good	Fairly good	Fairly bad	Very bad
9 During the past month, how would you rate your sleep quality overall?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

Participant's Initials: first middle last _____

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): _____

Derogatis Interview for Sexual Function (DISF-SR) (F) Female Version

Instruction: Below you will find a brief set of questions about your sexual activities. The questions are divided into different sections that ask about different aspects of your sexual experiences. One section asks about **sexual fantasies** or daydreams, while another inquires about the kinds of **sexual experiences** that you have. You are also asked about the nature of your **sexual arousal** and the quality of your **orgasm**. There are also a few other questions about different areas of your sexual relationship.

On some questions you are asked to respond in terms of a frequency scale, that is, "how often" do you perform the sexual activities asked about in that section. Some frequency scales go from "0 = not at all" to "8 = four or more times a day." Other frequency scales range from "0 = never" to "4 = always." In the case of other questions, you will be asked to respond in terms of a satisfaction scale. This type of scale tells how much you enjoyed, or were satisfied by the sexual activity being asked about. Some satisfaction scales range from "0 = could not be worse" to "8 = could not be better." Other satisfaction scales go from "0 = not at all satisfied," to "4 = extremely satisfied."

In every section of the inventory the scales required for that section are printed just above the questions so it will be easy to follow. Although it is brief, take your time with the inventory. **For each item, please check the scale number that best describes your personal experience.**

If you have any questions, please ask the person who gave you the inventory for help.

Section 1—Sexual Cognition/Fantasy

During the past 30 days or since the last time you filled out this inventory, how often have you had thoughts, dreams, or fantasies about:	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
1.1 A sexually attractive person	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.2 Erotic parts of a man's body (e.g., face, shoulders, legs)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.3 Erotic or romantic situations	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.4 Caressing, touching, undressing, or foreplay	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.5 Sexual intercourse, oral sex, touching to orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

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Derogatis Interview for Sexual Function (DISF-SR) (F) Female Version (continued)

Section 2—Sexual Arousal

During the past 30 days or since the last time you filled out this inventory, how often did you have the following experiences?	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
2.1 Feel sexually aroused while alone	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.2 Actively seek sexual satisfaction	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.3 Feel sexually aroused with a partner	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
	Never	Rarely	Sometimes	Usually	Always				
2.4 Have normal lubrication with masturbation	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄				
2.5 Have normal lubrication throughout sexual relations	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄				

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Derogatis Interview for Sexual Function (DISF-SR) (F) Female Version (continued)

Section 3—Sexual Behavior/Experiences

During the past 30 days or since the last time you filled out the inventory, how often did you engage in the following sexual activities?	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
3.1 Reading or viewing romantic or erotic books or stories	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
3.2 Masturbation	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
3.3 Casual kissing and petting	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
3.4 Sexual foreplay	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
3.5 Sexual intercourse, oral sex, etc.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

Section 4—Orgasm

During the past 30 days or since the last time you filled out this inventory, how satisfied have you been with the following?	Not at all	Slightly	Moderately	Highly	Extremely
4.1 Your ability to have an orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.2 The intensity of your orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.3 The ability to have multiple orgasms (if typical for you)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.4 Feelings of closeness and togetherness with your partner	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.5 Your sense of control (timing) of your orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.6 Feeling a sense of relaxation and well-being after orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

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Derogatis Interview for Sexual Function (DISF-SR) (F) Female Version (continued)

Section 5—Drive and Relationship

	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
5.1 With the partner of your choice, what would be your ideal frequency of sexual intercourse?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
	Not at all	Slightly	Moderately	Highly	Extremely				
5.2 During this period, how interested have you been in sex?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄				
5.3 During this period, how satisfied have you been with your personal relationship with your sexual partner?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄				
	Could not be worse	Very poor	Poor	Somewhat inadequate	Adequate	Above average	Good	Very good	Could not be better
5.4 In general, what would represent the best description of the quality of your sexual functioning?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

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Derogatis Interview for Sexual Function (DISF-SR) (M) Male Version

Instruction: Below you will find a brief set of questions about your sexual activities. The questions are divided into different sections that ask about different aspects of your sexual experiences. One section asks about **sexual fantasies** or daydreams, while another inquires about the kinds of **sexual experiences** that you have. You are also asked about the nature of your **sexual arousal** and the quality of your **orgasm**. There are also a few other questions about different areas of your sexual relationship.

On some questions you are asked to respond in terms of a frequency scale, that is, "how often" do you perform the sexual activities asked about in that section. Some frequency scales go from "0 = not at all" to "8 = four or more times a day." Other frequency scales range from "0 = never" to "4 = always." In the case of other questions, you will be asked to respond in terms of a satisfaction scale. This type of scale tells how much you enjoyed, or were satisfied by the sexual activity being asked about. Some satisfaction scales range from "0 = could not be worse" to "8 = could not be better." Other satisfaction scales go from "0 = not at all satisfied," to "4 = extremely satisfied."

In every section of the inventory the scales required for that section are printed just above the questions so it will be easy to follow. Although it is brief, take your time with the inventory. **For each item, please check the scale number that best describes your personal experience.**

If you have any questions, please ask the person who gave you the inventory for help.

Section 1—Sexual Cognition/Fantasy

During the past 30 days or since the last time you filled out this inventory, how often have you had thoughts, dreams, or fantasies about:	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
1.1 A sexually attractive person	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.2 Erotic parts of a woman's body (e.g., face, genitals, legs)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.3 Erotic or romantic situations	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.4 Caressing, touching, undressing, or foreplay	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.5 Sexual intercourse, oral sex, touching to orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

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Derogatis Interview for Sexual Function (DISF-SR) (M) Male Version (continued)

Section 2—Sexual Arousal

During the past 30 days or since the last time you filled out this inventory, how often did you have the following experiences?	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
2.1 A full erection upon awakening	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.2 A full erection during a sexual fantasy or daydream	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.3 A full erection while looking at a sexually arousing person, movie, or picture	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.4 A full erection during masturbation	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.5 A full erection throughout the phases of a normal sexual response cycle, that is from undressing and foreplay through intercourse and orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

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Derogatis Interview for Sexual Function (DISF-SR) (M) Male Version (continued)

Section 3—Sexual Behavior/Experiences

During the past 30 days or since the last time you filled out the inventory, how often did you engage in the following sexual activities?	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
3.1 Reading or viewing romantic or erotic books or stories	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	<input type="checkbox"/> _5	<input type="checkbox"/> _6	<input type="checkbox"/> _7	<input type="checkbox"/> _8
3.2 Masturbation	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	<input type="checkbox"/> _5	<input type="checkbox"/> _6	<input type="checkbox"/> _7	<input type="checkbox"/> _8
3.3 Casual kissing and petting	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	<input type="checkbox"/> _5	<input type="checkbox"/> _6	<input type="checkbox"/> _7	<input type="checkbox"/> _8
3.4 Sexual foreplay	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	<input type="checkbox"/> _5	<input type="checkbox"/> _6	<input type="checkbox"/> _7	<input type="checkbox"/> _8
3.5 Sexual intercourse, oral sex, etc.	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	<input type="checkbox"/> _5	<input type="checkbox"/> _6	<input type="checkbox"/> _7	<input type="checkbox"/> _8

Section 4—Orgasm

During the past 30 days or since the last time you filled out this inventory, how <u>satisfied</u> have you been with the following?	Not at all	Slightly	Moderately	Highly	Extremely
4.1 Your ability to have an orgasm	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
4.2 The intensity of your orgasm	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
4.3 The length or duration of your orgasm	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
4.4 The amount of seminal liquid that you ejaculate	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
4.5 Your sense of control (timing) of your orgasm	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
4.6 Feeling a sense of relaxation and well-being after orgasm	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4

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Derogatis Interview for Sexual Function (DISF-SR) (M) Male Version (continued)

Section 5—Drive and Relationship

	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
5.1 With the partner of your choice, what would be your ideal frequency of sexual intercourse?	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	<input type="checkbox"/> _5	<input type="checkbox"/> _6	<input type="checkbox"/> _7	<input type="checkbox"/> _8
	Not at all	Slightly	Moderately	Highly	Extremely				
5.2 During this period, how interested have you been in sex?	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4				
5.3 During this period, how satisfied have you been with your personal relationship with your sexual partner?	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4				
	Could not be worse	Very poor	Poor	Somewhat inadequate	Adequate	Above average	Good	Very good	Could not be better
5.4 In general, what would represent the best description of the quality of your sexual functioning?	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	<input type="checkbox"/> _5	<input type="checkbox"/> _6	<input type="checkbox"/> _7	<input type="checkbox"/> _8

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day month year

Food Cravings Questionnaire—Trait

Please indicate the extent to which you agree with each statement below, in general, by checking the appropriate box.

	Never OR NA	Rarely	Some- times	Often	Usually	Always
1 Being with someone who is eating often makes me hungry.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
2 When I crave something, I know I won't be able to stop eating once I start.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
3 If I eat what I am craving, I often lose control and eat too much.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
4 I hate it when I give in to cravings.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
5 Food cravings invariably make me think of ways to get what I want to eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
6 I feel like I have food on my mind all the time.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
7 I often feel guilty for craving certain foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
8 I find myself preoccupied with food.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
9 I eat to feel better.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
10 Sometimes, eating makes things seem just perfect.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
11 Thinking about my favorite foods makes my mouth water.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
12 I crave foods when my stomach is empty.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
13 I feel as if my body asks for certain foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
14 I get so hungry that my stomach seems like a bottomless pit.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
15 Eating what I crave makes me feel better.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
16 When I satisfy a craving, I feel less depressed.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
17 When I eat what I am craving, I feel guilty about myself.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
18 Whenever I have cravings, I find myself making plans to eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
19 Eating calms me down.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

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Food Cravings Questionnaire—Trait (continued)

	Never OR NA	Rarely	Some- times	Often	Usually	Always
20 I crave foods when I am bored, angry, or sad.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
21 I feel less anxious after I eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
22 If I get what I am craving, I cannot stop myself from eating it.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
23 When I crave certain foods, I usually try to eat them as soon as I can.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
24 When I eat what I crave, I feel great.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
25 I have no will power to resist my food crave.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
26 Once I start eating, I have trouble stopping.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
27 I can't stop thinking about eating, no matter how hard I try.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
28 I spend a lot of time thinking about whatever it is I will eat next.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
29 If I give in to a food craving, all control is lost.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
30 When I'm stressed out, I crave food.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
31 I daydream about food.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
32 Whenever I have a food craving, I keep on thinking about eating until I actually eat the food.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
33 If I am craving something, thoughts of eating it consume me.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
34 My emotions often make me want to eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
35 Whenever I go to a buffet, I end up eating more than what I needed.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
36 It is hard for me to resist the temptation to eat appetizing foods that are in my reach.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
37 When I am with someone who is overeating, I usually overeat too.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
38 When I eat food, I feel comforted.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
39 I crave foods when I'm upset.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

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day month year

Food Cravings Questionnaire—State (FCQ—S)

Below is a list of comments made by people about their eating habits. Please check one answer for each comment that indicates how much you agree with the comment **right now, at this very moment**. Notice that some questions refer to foods in general while others refer to one or more specific foods. Please respond to each item as honestly as possible.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1 I have an intense desire to eat [one or more specific foods].	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
2 I'm craving [one or more specific foods].	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
3 I have an urge for [one or more specific foods]	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
4 Eating [one or more specific foods] would make things seem just perfect.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
5 If I were to eat what I am craving, I am sure my mood would improve.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
6 Eating [one or more specific foods] would feel wonderful.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
7 If I ate something, I wouldn't feel so sluggish and lethargic.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
8 Satisfying my craving would make me feel less grouchy and irritable.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
9 I would feel more alert if I could satisfy my craving.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
10 If I had [one or more specific foods], I could not stop eating it.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
11 My desire to eat [one or more specific foods] seems overpowering.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
12 I know I'm going to keep on thinking about [one or more specific foods] until I actually have it.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
13 I am hungry.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
14 If I ate right now, my stomach wouldn't feel as empty.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
15 I feel weak because of not eating.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

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Food Craving Inventory (FCI-II)

For each of the foods listed below, please check the appropriate box.

Note: A craving is defined as an intense desire to consume a particular food or food type that is difficult to resist.

Over the past month, how often have you experienced a craving for...	Never	Rarely (once or twice)	Sometimes	Often	Always/Almost Every Day
1 Cake	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
2 Pizza	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
3 Fried chicken	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
4 Gravy	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
5 Sandwich bread	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
6 Sausage	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
7 French fries	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
8 Cinnamon rolls	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
9 Rice	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
10 Hot dog	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
11 Hamburger	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
12 Biscuits	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
13 Ice cream	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
14 Pasta	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
15 Fried fish	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
16 Cookies	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
17 Chocolate	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
18 Pancakes or waffles	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
19 Corn bread	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
20 Chips	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
21 Rolls	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
22 Cereal	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
23 Donuts	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
24 Candy	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
25 Brownies	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
26 Bacon	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
27 Steak	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
28 Baked potato	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

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Eating Inventory

- 1 When I smell a sizzling steak or see a juicy piece of meat, I find it very difficult to keep from eating, even if I have just finished a meal. ₁ True ₀ False
- 2 I usually eat too much at social occasions, like parties and picnics. ₁ True ₀ False
- 3 I am usually so hungry that I eat more than three times a day. ₁ True ₀ False
- 4 When I have eaten my quota of calories, I am usually good about not eating anymore. ₁ True ₀ False
- 5 Dieting is so hard for me because I just get too hungry. ₁ True ₀ False
- 6 I deliberately take small helpings as a means of controlling my weight. ₁ True ₀ False
- 7 Sometimes things just taste so good that I keep on eating even when I am no longer hungry. ₁ True ₀ False
- 8 Since I am often hungry, I sometimes wish that while I am eating, an expert would tell me that I have had enough or that I can have something more to eat. ₁ True ₀ False
- 9 When I feel anxious, I find myself eating. ₁ True ₀ False
- 10 Life is too short to worry about dieting. ₁ True ₀ False
- 11 Since my weight goes up and down, I have gone on reducing diets more than once. ₁ True ₀ False
- 12 I often feel so hungry that I just have to eat something. ₁ True ₀ False
- 13 When I am with someone who is overeating, I usually overeat too. ₁ True ₀ False
- 14 I have a pretty good idea of the number of calories in common food. ₁ True ₀ False
- 15 Sometimes when I start eating, I just can't seem to stop. ₁ True ₀ False
- 16 It is not difficult for me to leave something on my plate. ₁ True ₀ False
- 17 At certain times of the day, I get hungry because I have gotten used to eating then. ₁ True ₀ False
- 18 While on a diet, if I eat food that is not allowed, I consciously eat less for a period of time to make up for it. ₁ True ₀ False

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Eating Inventory (continued)

- 19** Being with someone who is eating often makes me hungry to eat also. True False
- 20** When I feel blue, I often overeat. True False
- 21** I enjoy eating too much to spoil it by counting calories or watching my weight. True False
- 22** When I see a real delicacy, I often get so hungry that I have to eat right away. True False
- 23** I often stop eating when I am not really full as a conscious means of limiting the amount I eat. True False
- 24** I get so hungry that my stomach often seems like a bottomless pit. True False
- 25** My weight has hardly changed at all in the last ten years. True False
- 26** I am always hungry so it is hard for me to stop eating before I finish the food on my plate. True False
- 27** When I feel lonely, I console myself by eating. True False
- 28** I consciously hold back at meals in order not to gain weight. True False
- 29** I sometimes get very hungry late in the evening or at night. True False
- 30** I eat anything I want, any time I want. True False
- 31** Without even thinking about it, I take a long time to eat. True False
- 32** I count calories as a conscious means of controlling my weight. True False
- 33** I do not eat some foods because they make me fat. True False
- 34** I am always hungry enough to eat at any time. True False
- 35** I pay a great deal of attention to changes in my figure. True False
- 36** While on a diet, if I eat a food that is not allowed, I often splurge and eat other high calorie foods. True False

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Eating Inventory (continued)

Please check one answer that is most appropriate to you for each question below.

37	How often are you dieting in a conscious effort to control your weight?	<input type="checkbox"/> ₁ Rarely	<input type="checkbox"/> ₂ Sometimes	<input type="checkbox"/> ₃ Usually	<input type="checkbox"/> ₄ Always
38	Would a weight fluctuation of 5 pounds affect the way you live your life?	<input type="checkbox"/> ₁ Rarely	<input type="checkbox"/> ₂ Sometimes	<input type="checkbox"/> ₃ Usually	<input type="checkbox"/> ₄ Always
39	How often do you feel hungry?	<input type="checkbox"/> ₁ Rarely	<input type="checkbox"/> ₂ Sometimes	<input type="checkbox"/> ₃ Usually	<input type="checkbox"/> ₄ Always
40	Do your feelings of guilt about overeating help you to control your food intake?	<input type="checkbox"/> ₁ Rarely	<input type="checkbox"/> ₂ Sometimes	<input type="checkbox"/> ₃ Usually	<input type="checkbox"/> ₄ Always
41	How difficult would it be for you to stop eating halfway through dinner and not eat for the next four hours?	<input type="checkbox"/> ₁ Easy	<input type="checkbox"/> ₃ Moderately difficult	<input type="checkbox"/> ₂ Slightly difficult	<input type="checkbox"/> ₄ Very difficult
42	How conscious are you of what you are eating?	<input type="checkbox"/> ₁ Not at all	<input type="checkbox"/> ₃ Moderately	<input type="checkbox"/> ₂ Slightly	<input type="checkbox"/> ₄ Extremely
43	How frequently do you avoid "stocking up" on tempting foods?	<input type="checkbox"/> ₁ Almost never	<input type="checkbox"/> ₃ Usually	<input type="checkbox"/> ₂ Seldom	<input type="checkbox"/> ₄ Almost always
44	How likely are you to shop for low calorie foods?	<input type="checkbox"/> ₁ Unlikely	<input type="checkbox"/> ₃ Moderately likely	<input type="checkbox"/> ₂ Slightly likely	<input type="checkbox"/> ₄ Very likely
45	Do you eat sensibly in front of others and splurge alone?	<input type="checkbox"/> ₁ Never	<input type="checkbox"/> ₂ Rarely	<input type="checkbox"/> ₃ Often	<input type="checkbox"/> ₄ Always
46	How likely are you to consciously eat slowly in order to cut down on how much you eat?	<input type="checkbox"/> ₁ Unlikely	<input type="checkbox"/> ₃ Moderately likely	<input type="checkbox"/> ₂ Slightly likely	<input type="checkbox"/> ₄ Very likely
47	How frequently do you skip dessert because you are no longer hungry?	<input type="checkbox"/> ₁ Almost never	<input type="checkbox"/> ₃ At least once a week	<input type="checkbox"/> ₂ Seldom	<input type="checkbox"/> ₄ Almost every day
48	How likely are you to consciously eat less than you want?	<input type="checkbox"/> ₁ Unlikely	<input type="checkbox"/> ₃ Moderately likely	<input type="checkbox"/> ₂ Slightly likely	<input type="checkbox"/> ₄ Very likely
49	Do you go on eating binges though you are not hungry?	<input type="checkbox"/> ₁ Never	<input type="checkbox"/> ₃ Sometimes	<input type="checkbox"/> ₂ Rarely	<input type="checkbox"/> ₄ At least once a week
50	To what extent does this statement describe your eating behavior? "I start dieting in the morning, but because of any number of things that happen during the day, by evening I have given up and eat what I want, promising myself to start dieting again tomorrow."	<input type="checkbox"/> ₁ Not like me	<input type="checkbox"/> ₃ Pretty good description of me	<input type="checkbox"/> ₂ Little like me	<input type="checkbox"/> ₄ Describes me perfectly
51	On a scale of 0 to 5, where 0 means no restraint in eating (eating whatever you want, whenever you want it) and 5 means total restraint (constantly limiting food intake and never "giving in"), what number would you give yourself?	<input type="checkbox"/> ₀ Eat whatever you want, whenever you want it	<input type="checkbox"/> ₂ Often eat whatever you want, whenever you want it	<input type="checkbox"/> ₁ Usually eat whatever you want, whenever you want it	<input type="checkbox"/> ₃ Often limit food intake, but often "give in"
		<input type="checkbox"/> ₄ Usually limit food intake, rarely "give in"	<input type="checkbox"/> ₅ Constantly limiting food intake, never "giving in"		

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Weight Efficacy Lifestyle Questionnaire (WEL)

This form describes some typical eating situations. Everyone has situations which make it very hard for them to keep their weight down. The following are a number of situations relating to eating patterns and attitudes. This form will help you to identify the eating situations which you find the hardest to manage.

Read each situation listed below and decide how confident (or certain) you are that you will be able to resist eating in each of the difficult situations. In other words, pretend that you are in the eating situation right now. On a scale from 0 (not confident) to 9 (very confident), choose ONE number that reflects how confident you feel now about being able to **successfully resist** the desire to eat. Check this number for each item.

I am confident that:	Not confident at all that you can resist the desire to eat					Very confident that you can resist the desire to eat				
	0	1	2	3	4	5	6	7	8	9
1 I can resist eating when I am anxious (nervous).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 I can control my eating on the weekends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 I can resist eating even when I have to say "no" to others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 I can resist eating when I feel physically run down.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 I can resist eating when I am watching TV.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 I can resist eating when I am depressed (or down).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 I can resist eating when there are many different kinds of food available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 I can resist eating even when I feel it is impolite to refuse a second helping.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 I can resist eating even when I have a headache.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Weight Efficacy Lifestyle Questionnaire (WEL) (continued)

I am confident that:	Not confident at all that you can resist the desire to eat					Very confident that you can resist the desire to eat				
	0	1	2	3	4	5	6	7	8	9
10 I can resist eating when I am reading.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 I can resist eating when I am angry (or irritable).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12 I can resist eating even when I am at a party.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13 I can resist eating even when others are pressuring me to eat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14 I can resist eating when I am in pain.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15 I can resist eating just before going to bed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16 I can resist eating when I have experienced failure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17 I can resist eating when high-calorie foods are available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18 I can resist eating even when I think others will be upset if I don't eat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19 I can resist eating when I feel uncomfortable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20 I can resist eating when I am happy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Multiaxial Assessment of Eating Disorder Symptoms (MAEDS)

Instructions: Using the scale shown, please rate the following items on a scale from 1 to 7. Please answer as truthfully as possible.

	Never	Very Rarely	Rarely	Some-times	Often	Very Often	Always
1 Fasting is a good way to lose weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
2 My sleep isn't as good as it used to be.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
3 I avoid eating for as long as I can.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
4 Certain foods are "forbidden" for me to eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
5 I can't keep certain foods in my house because I will binge on them.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
6 I can easily make myself vomit.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
7 I can feel that being fat is terrible.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
8 I avoid greasy foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
9 It's okay to binge and purge once in a while.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
10 I don't eat certain foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
11 I think I am a good person.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
12 My eating is normal.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
13 I can't seem to concentrate lately.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
14 I try to diet by fasting.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
15 I vomit to control my weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
16 Lately nothing seems enjoyable anymore.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
17 Laxatives help keep you slim.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
18 I don't eat red meat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
19 I eat so rapidly I can't even taste my food.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Participant's Initials: _____
first middle last

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Center Number: ____ Participant Number: ____ Participant's Initials: first middle last _____

Multiaxial Assessment of Eating Disorder Symptoms (MAEDS) (continued)

	Never	Very Rarely	Rarely	Sometimes	Often	Very Often	Always
20 I do everything I can to avoid being overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
21 When I feel bloated, I must do something to rid myself of that feeling.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
22 I overeat too frequently.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
23 It's okay to be overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
24 Recently I have felt that I am a worthless person.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
25 I would be very upset if I gained 2 pounds.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
26 I crave sweets and carbohydrates.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
27 I lose control when I eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
28 Being fat would be terrible.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
29 I have thought seriously about suicide lately.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
30 I don't have any energy anymore.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
31 I eat small portions to control my weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
32 I eat 3 meals a day.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
33 Lately I have been easily irritated.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
34 Some foods should be totally avoided.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
35 I use laxatives to control my weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
36 I am terrified by the thought of being overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
37 Purging is a good way to lose weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
38 I avoid fatty foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

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Center Number: _____ Participant Number: _____ Participant's Initials: _____
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Multiaxial Assessment of Eating Disorder Symptoms (MAEDS) (continued)

	Never	Very Rarely	Rarely	Some-times	Often	Very Often	Always
39 Recently I have felt pretty blue.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
40 I am obsessed with becoming overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
41 I don't eat fried foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
42 I skip meals.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
43 Fat people are unhappy.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
44 People are too concerned with the way I eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
45 I feel good when I skip meals.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
46 I avoid foods with sugar.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
47 I hate it when I feel fat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
48 I am too fat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
49 I eat until I am completely stuffed.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
50 I hate to eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
51 I feel guilty about a lot of things these days.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
52 I'm very careful of what I eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
53 I can "hold off" and not eat even if I am hungry.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
54 I eat even when I am not hungry.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
55 Fat people are disgusting.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
56 I wouldn't mind gaining a few pounds.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

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Center Number: ____ Participant Number: _____ Participant's Initials: _____
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Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): _____
day month year

Body Shape Questionnaire (BSQ)

We would like to know how you have been feeling about your appearance over the **past four weeks**. Please read each question and check the box for the appropriate choice. Please answer all the questions.

Over the Past Four Weeks...	Never	Rarely	Sometimes	Often	Very Often	Always
1 Has feeling bored made you brood about your shape?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
2 Have you been so worried about your shape that you have been feeling that you ought to diet?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
3 Have you thought that your thighs, hips, or bottom are too large for the rest of you?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
4 Have you been afraid that you might become fat (or fatter)?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
5 Have you worried about your flesh not being firm enough?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
6 Has feeling full (e.g., after eating a large meal) made you feel fat?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
7 Have you felt so bad about your shape that you have cried?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
8 Have you avoided running because your flesh might wobble?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
9 Has being with thin women/men made you feel self-conscious about your shape?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
10 Have you worried about your thighs spreading out when sitting down?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
11 Has eating even a small amount of food made you feel fat?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
12 Have you noticed the shape of other women/men and felt that your own shape compared unfavorably?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
13 Has thinking about your shape interfered with your ability to concentrate (e.g., while watching TV, reading, listening to conversations)?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
14 Has being naked, such as when taking a bath, made you feel fat?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
15 Have you avoided wearing clothes which make you particularly aware of the shape of your body?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
16 Have you imagined cutting off fleshy areas of your body?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Participant's Initials: _____
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Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Body Shape Questionnaire (BSQ) (continued)

Over the Past Four Weeks...	Never	Rarely	Some- times	Often	Very Often	Always
17 Has eating sweets, cakes or other high calorie food made you feel fat?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
18 Have you not gone out on social occasions (e.g., parties) because you have felt bad about your shape?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
19 Have you felt excessively large and rounded?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
20 Have you felt ashamed of your body?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
21 Has worry about your shape made you diet?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
22 Have you felt happiest about your shape when your stomach has been empty?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
23 Have you thought that you are the shape you are because you lack self-control?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
24 Have you worried about other people seeing rolls of flesh around your waist or stomach?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
25 Have you felt that it is not fair that other women/men are thinner than you?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
26 Have you vomited in order to feel thinner?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
27 When in company, have you worried about taking up too much room (e.g., sitting on a sofa or bus seat)?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
28 Have you worried about your flesh being dimply?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
29 Has seeing your reflection (e.g., in a mirror or shop window) made you feel bad about your shape?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
30 Have you pinched areas of your body to see how much fat is there?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
31 Have you avoided situations where people could see your body (e.g., communal changing rooms or swimming pools)?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
32 Have you taken laxatives in order to feel thinner?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
33 Have you been particularly self-conscious about your shape when in the company of other people?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
34 Has worry about your shape made you feel you ought to exercise?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

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Center Number: ____ Participant Number: _____ Participant's Initials: first middle last _____

Clinic Weight

Weight date and time: ____/____/____ : ____
day month year 00:00 to 23:59

Staff initials: first middle last _____

OR Not done → Specify reason (use codelist below): ____

Clinic weight (if the two measurements are more than 0.1 kg apart, measure weight a third time):

Weight 1: _____ . ____ kg

Weight 2: _____ . ____ kg

Weight 3: _____ . ____ kg

Weight of gown: _____ . ____ kg

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Seven-Day Physical Activity Recall (PAR)

Today's date: ____/____/____ Day (check only one): Mon Tues Wed Thurs Fri Sat Sun **OR Not done** → Specify reason (use code list below): _____

1 Were you employed in the last seven days? 0 No → Skip to question 3 1 Yes
 Interviewer initials: _____
first middle last

2 If Yes: Which days (check all that apply)?
 Mon Tues Wed Thurs Fri Sat Sun

3 Which days do you consider your weekend, or non-work, days?
 Mon Tues Wed Thurs Fri Sat Sun

Day #	Date	Sleep Time		Work Time			Morning (in minutes)			Afternoon (in minutes)			Evening (in minutes)		
		In Bed	Up	Start	Stop	Mod.	Hard	Very Hard	Mod.	Hard	Very Hard	Mod.	Hard	Very Hard	
7 <small>(yesterday)</small>	____/____/____ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	
6	____/____/____ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	
5	____/____/____ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	
4	____/____/____ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	
3	____/____/____ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	
2	____/____/____ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	
1 <small>(1 week ago)</small>	____/____/____ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	

Not Done Codes: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Seven-Day Physical Activity Recall (PAR) (continued)

4 Compared to your physical activity over the past three months, was last week's physical activity more, less, or about the same (check only one)?

- ₁ More
₂ Less
₃ About the same

Interviewer: Please answer questions below and note any comments on interview.

5 Were there any problems with the Seven-Day PAR interview?

- ₀ No
₁ Yes

6 Do you think this was a valid Seven-Day PAR interview?

- ₀ No
₁ Yes

7 Were there any activities reported by the participant that you don't know how to classify?

- ₀ No
₁ Yes

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

6-Day Food Record

Complete below OR Not done → Specify reason (use Codelist below): _____

Staff initials: _____
first middle last

			Replacement Values		
Day of DLW	Date of Record	Record Quality (check only one)	Day of DLW	Date of Record	Record Quality (check only one)
1	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	8	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
2	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	9	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
3	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	10	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
4	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	11	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
5	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	12	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
6	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	13	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: ____ Participant Number: _____ Participant's Initials:
first middle last

Concomitant Medications Log

Record any medications taken after start of baseline visit, including over-the-counter and prescription drugs, vitamins, supplements, and herbal medications. Update form for each visit and mark corresponding additional box.

Send copies of this form with each submission starting with baseline:

Baseline 1 Baseline 2 Month 1 Month 3 Month 6 Month 9 Month 12 Month 18 Month 24

Medication	Start Date or <input checked="" type="checkbox"/> if Pre-study	Stop Date or <input checked="" type="checkbox"/> if Continuing	Indication
1 Study vitamin-mineral supplement	____/____/____ <small>day month year</small>	____/____/____ <small>day month year</small>	
2 Study calcium supplement	____/____/____ <small>day month year</small>	____/____/____ <small>day month year</small>	
3	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
4	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
5	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
6	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
7	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
8	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
9	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
10	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
11	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
12	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	

Center Number: ____ Participant Number: ____ Participant's Initials:
first middle last

Study Calcium Supplement 1000 mg		
Medication	Start Date	Stop Date
Study calcium supplement, 1000 mg	____/____/____ <small>day month year</small>	____/____/____ <small>day month year</small>

