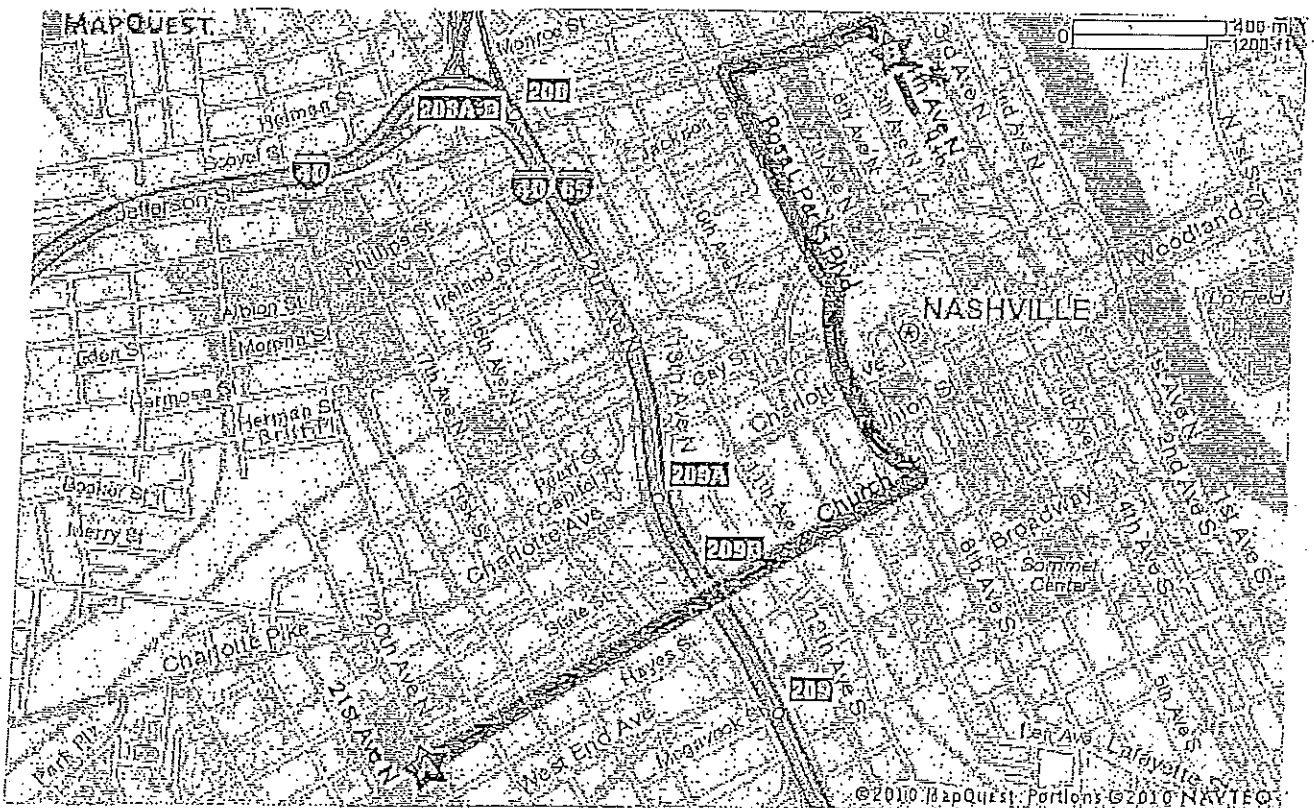


DRIVING DIRECTIONS TO SCALES NUTRITION AND WELLNESS CENTERS NEW LOCATION

- From the *old location* (2021 Church St) go Northeast on Church St. toward downtown
- Turn left onto James Robertson Pkwy / Rosa L Parks Blvd
- Turn left onto Rosa L Parks Blvd
- Turn right onto Jefferson St
- Turn right onto 4th Ave North
- Our new office (1010 4th Ave N.) is on the left

-
- From I-24 exit off 47 to Jefferson St
 - Travel west to 4th Ave and turn left at 4th Ave
 - Our new office is on the left 1010 4th Ave N
-



Scales Nutrition and Wellness Center

Patient Registration

Referring Physician (if applicable):

Patient's Last Name		_____	
Patient's First Name	MI	Spouse/Parent (Please circle)	
Address	Apartment No.	Name	
City, State, Zip Code		Address	
Home Phone	Cell Phone	City, State, Zip Code	
Email		Phone Number	
Date of Birth	Social Security	Insurance Information	
		Primary Insurance	
Sex (Please Circle)	Marital Status (Please Circle)	Name of Insurance Carrier	
Male Female	Married Single	_____	
	Divorced Widowed	ID Number	Group Number
Driver's License Number	State	Secondary Insurance	
Name of Employer	Phone No.	Name of Secondary Insurance	
Name of Emergency Contact	Phone No.	ID Number	Group Number

Privacy Practices (Please Initial Each Line)

_____ I acknowledge that Dr. Scales office personnel has given me a copy of their Notice of Privacy Practices. I authorize Dr. Scales and/or his office personnel to communicate with family, friends, or other health care providers as to my medical conditions. Listed below are the (specific) family members or health care providers to who I give permission to discuss my health status.

_____ The following listed names are (specific) family members or health care providers with whom I Do Not want my medical conditions discussed.

_____ I authorize Dr. Scales or his office personnel to leave messages on my voice mail at home and work, or email.

_____ I authorize other physicians or health care providers I have seen to exchange medical information with Dr. Scales, unless otherwise indicated.

Financial & Insurance Policy (Please Initial Each Line)

_____ I hereby authorize payment of benefits processed on by behalf to Scales Nutrition & Wellness Center for any services furnished to me by Dr. Scales. Furthermore, I authorize Dr. Scales and his office personnel to release any information obtained in the course of my evaluation & treatment to permit processing of claims for insurance reimbursement. I understand I am responsible for payment of any service(s) my insurance does not pay or process in a timely matter, customarily in 60 days.

_____ I understand I am financially responsible for paying my co-payments, co-insurance, deductibles and all outstanding balances. In the event that any past due balance is placed with a third party, I agree to pay any cost of such collection including the agency fees, legal/attorney fees and court cost.

_____ I understand if I cancel my appointment within 24 hours of the scheduled appointment or fail to keep a scheduled appointment, I will be charged and responsible for paying twenty-five (\$25) dollars for an internal medicine & medication management appointment, seventy (\$70) dollars for a psychiatry appointment, fifty (\$50) dollars for a therapy appointment, and appropriate charge(s) for a missed nutrition appointment.

Signature of Patient (Parent or guardian if patient is a minor) _____ Date _____

Scales Nutrition and Wellness Center
1010 Fourth Avenue North, Nashville, TN 37219 (615) 724-0865

Your rights:

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

You may have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to the Secretary of Health and Human Services or us if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at (615) 724-0865.

Signature below is only acknowledgement that you have received this notice of our Privacy Practices:

Print name _____ Signature _____ Date _____

**Scales Nutrition and Wellness Center
Patient Questionnaire, Page 1 of 4**

Date: _____

Name: _____

Age: _____

Occupation: _____

Marital Status: M S D W

Please indicate if you have suffered any of the following:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gout	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bladder Infections	<input type="checkbox"/> Goiter	<input type="checkbox"/> Hernia	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cancer
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Psychiatric Disorder

Other Medical Problems not noted above: _____

List any Hospitalizations for illness, trauma, or surgery below, please give reason and date of hospitalization:

DATE:	Reason for Hospitalization:

Medications: Please list all medications including over the counter medications, antacids, laxatives, birth control pills, vitamins, herbs, etc.

Drug	Dose	How many times per day?	Length of time taken

Allergies: Are you allergic to any medications, latex, or foods? If so, Please list them and the problem that you experienced.

Medication/Food Allergy	Problem Experienced

Name _____

Date _____

Scales Nutrition and Wellness Center
Patient Questionnaire, Page 2 of 4

Vaccinations within the past ten years (please include date it was given):

Tetanus (TT, Td, or DPT) _____ MMR: _____
 Pneumovax: _____ Hepatitis B: _____
 Influenza: _____ HIB: _____

Health Maintenance Date (include dates if known):

PPD (for TB) _____ Flexible Sig/Colonoscopy: _____
 Hemocult: _____ Pap Smear/PSA: _____
 Mammography: _____ Breast/Testes: _____
 Stress Test: _____ EKG: _____
 Chest X-ray: _____ Echocardiogram: _____

Personal Health Habits:

Do you smoke?	Y	N	How many years? _____
Have you ever smoked?	Y	N	How many years? _____
			How many packs per day? _____
Do you drink alcohol?	Y	N	How many drinks per week? _____
			Date of last drink: _____
Do you exercise regularly?	Y	N	What kind of exercise? _____
			How often? _____
Do you use recreational drugs?	Y	N	What kind? _____
			How often? _____
Do you have any problems sleeping?	Y	N	How many hours nightly? _____
Do you follow a special diet?	Y	N	What kind? _____
Have you ever been exposed to Toxins or fumes at home/work?	Y	N	What kind? _____

Review of Symptoms:

Have you had any of the following problems? If so, which ones and when did they start?

General:	No	Yes	When/Explain
Skin/rash	___	___	_____
Bruise easily	___	___	_____
Joints ever painful?	___	___	_____
Lost or Gained weight?	___	___	_____
Sensitive to Heat/Cold	___	___	_____

Head and Neck

Frequent Headaches	___	___	_____
Frequent Cold's	___	___	_____
Problems with Vision	___	___	_____
Hearing	___	___	_____
Frequent Nosebleeds	___	___	_____
Hair Loss	___	___	_____
Difficulty Seeing at Night	___	___	_____
Taste Alteration	___	___	_____
Bleeding Gums	___	___	_____
Dry Mouth	___	___	_____
Sores in Mouth	___	___	_____

Name: _____

Date: _____

**Scales Nutrition and Wellness Center
Patient Questionnaire, Page 3 of 4**

	No	Yes	When/Explain
Chest and Cardiovascular			
Shortness of breath	_____	_____	_____
Wheezing	_____	_____	_____
Chest Discomfort	_____	_____	_____
Extremities Cold/Numb	_____	_____	_____
Swelling of Hands/Feet	_____	_____	_____
Frequent Coughing	_____	_____	_____
Coughing up Blood	_____	_____	_____
Daytime Drowsiness	_____	_____	_____
Loud snoring	_____	_____	_____
Unrested after Sleep	_____	_____	_____
Gastrointestinal			
Stomach Pains	_____	_____	_____
Frequent Nausea	_____	_____	_____
Frequent Constipation	_____	_____	_____
Black Stools	_____	_____	_____
Blood or Pus in Stool	_____	_____	_____
Vomiting Blood	_____	_____	_____
Frequent Diarrhea	_____	_____	_____
Trouble Digesting food	_____	_____	_____
Frequent Laxative Use	_____	_____	_____
Genitourinary			
Urinate >1 time/night	_____	_____	_____
Urinate >6 times/day	_____	_____	_____
Burning during urination	_____	_____	_____
Urine Brown or Bloody	_____	_____	_____
Sexual Difficulties	_____	_____	_____
Musuloskeletal			
Knee Problems	_____	_____	_____
Back Problems	_____	_____	_____
Leg Cramps	_____	_____	_____
Joint Pain	_____	_____	_____
Change in Mobility	_____	_____	_____
Neurological			
Dizziness	_____	_____	_____
Memory Loss	_____	_____	_____
Tremors	_____	_____	_____
Seizures	_____	_____	_____
Headaches/Migraines	_____	_____	_____

Name: _____

Date: _____

QUESTIONNAIRE ON EATING AND WEIGHT PATTERNS – REVISED

Last Name _____ First Name _____ M.I. _____

Date _____

Thank you for completing this questionnaire. Please circle the appropriate number or response, or write in information where asked. You may skip any question that you do not understand or wish not to answer.

Please Begin with question #7

1. What has been your highest weight ever (when not pregnant)? _____

2. How old were you when you were first overweight (at least 10 lbs. as a child or 15 lbs. as an adult?) If you are not sure, what is your best guess? _____

3. How many times (approximately) have you lost 20 lbs. or more – when you weren't sick – and then gained it back?

Never

Once or Twice

Three or four times

Five times or more

4. During the past six months, did you often eat within any two-hour period what most people would regard as an unusually large amount of food?

Yes

No (if no, skip to question 9)

5. During the times when you ate this way, did you often feel you couldn't stop eating or control what or how much you were eating?

Yes

No (if no, skip to question 9)

6. During the past six months how often, on average, did you have times when you ate this way – that is, large amounts of food plus the feeling that your eating was out of control? (There may have been some weeks when it was not present – just average those weeks in with the total)

- Less than one day a week
- One day a week
- Two or Three days a week
- Four or Five days a week
- Nearly everyday

7. Did you usually have any of the following experiences during these occasions?

- | | | |
|---|-----|----|
| <input type="checkbox"/> Eating much more rapidly than usual? | Yes | No |
| <input type="checkbox"/> Eating until you felt uncomfortably full? | Yes | No |
| <input type="checkbox"/> Eating Large amounts of food when you didn't feel physically hungry? | Yes | No |
| <input type="checkbox"/> Eating alone because you were embarrassed by how much you were eating? | Yes | No |
| <input type="checkbox"/> Feeling disgusted with yourself, depressed, or feeling very guilty after overeating? | Yes | No |

8. Think about a typical time when you ate this way – that is, large amounts of food plus feeling that your eating was out of control.

* What time of day did this episode start?

- Morning (8 AM to 12 Noon)
- Early Afternoon (12 Noon to 4 PM)
- Late Afternoon (4 PM to 7 PM)
- Evening (7 PM to 10 PM)
- Night (After 10 PM)

* Approximately how long did this episode of eating last, from the time you started to eat to when you stopped and didn't eat again for at least two hours?

_____ Hours _____ Minutes

* As best you can remember, please list everything you might have eaten or drank during that episode: If you are for more than two hours, describe the foods eaten and drank during the two hours that you ate the most. Be specific – include brand names where possible, and amounts as best you can estimate. (For example: 7 ounces Ruffles potato chips; 1 cup Breyer's chocolate ice cream with 2 teaspoons hot fudge; 2 8-ounce glasses of coca-cola; 1 & ½ ham and cheese sandwiches with mustard.

* At the same time this episode started, how long had it been since you had previously finished eating a meal or snack?

_____ Hours _____ Minutes

16. During the past three months, did you ever exercise for more than an hour specifically in order to avoid gaining weight after binge eating?

Yes No

If yes; How often on average was that?

Less than once a week Once a week 2 or 3 times a week
4 or 5 times a week More than 5 times a week

17. During the past three months did you ever take more than twice the recommended dose of a diet pill in order to avoid gaining weight after binge eating?

Yes No

If yes; How often on average was that?

Less than once a week Once a week 2 or 3 times a week
4 or 5 times a week More than 5 times a week

18. During the past six months did you go to any meetings of an organized weight control program? (e.g. Weight Watchers, Optifast, Nutrisystem) or a self-help group (e.g. TOPS, Overeaters Anonymous)?

Yes No

If yes: Name of the program: _____

19. Since you have been an adult – 18 years old – how much time have you spent on a diet, been trying to follow a diet, or in some way been limiting how much you were eating in order to lose weight or keep from regaining weight you had lost?

Would you say...?

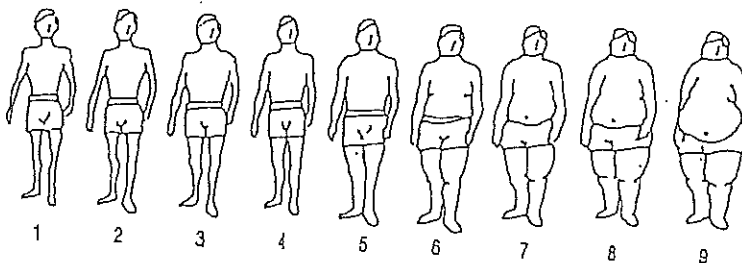
None or hardly any of the time About a quarter of the time
About half the time About three-quarters of the time Nearly all the time

20. SKIP THIS QUESTION IF YOU'VE NEVER HAD EPISODES OF EATING UNUSUALLY LARGE AMOUNTS OF FOOD ALONG WITH THE SENSE OF LOSE OF CONTROL: How old were you when you first had times when you ate large amounts of food and felt that your eating was out of control? If you are not sure, what is your best guess?

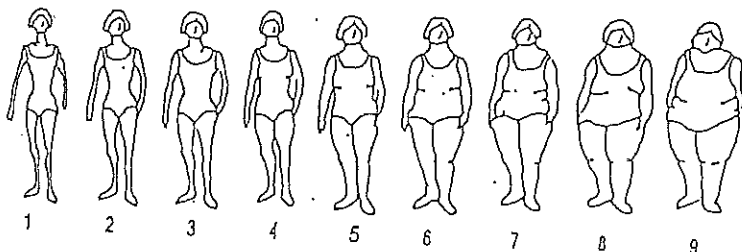
_____ Years

21. Please take a look at these silhouettes. Put a circle around the silhouettes which most resemble the body build of your natural father and mother at their heaviest. If you have no knowledge of your biological father and/or mother, don't circle anything for that parent.

YOUR FATHER



YOUR MOTHER



EDQOL

INSTRUCTIONS: Please answer the following statements according to how well they describe you in the last 30 days. Please be as open as possible. There are no right or wrong answers. Fill in the circle in the appropriate column. For those items that do not apply to you, please leave them blank.

In the last 30 days....

	Never	Rarely	Sometimes	Often	Always
Psychological:					
1. How often has your eating/weight resulted in you feeling embarrassed or "different"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. How often has your eating/weight made you feel worse about yourself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. How often has your eating/weight made you not want to be with people?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. How often has your eating/weight resulted in you believing that you will never get better?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. How often as your eating/weight made you feel lonely?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. How often has your eating/weight resulted in less interest or pleasure in activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. How often has your eating/weight led you to not care about yourself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. How often has your eating/weight made you feel odd, weird, or unusual?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. How often has your eating/weight resulted in avoiding eating in front of others?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physical Cognitive:					
10. How often has your eating/weight caused cold hands or feet?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. How often has your eating/weight caused frequent headaches?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. How often has your eating/weight caused weakness?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. How often has your eating/weight affected your ability to pay attention when you wanted to?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. How often has your eating/weight affected your ability to comprehend some verbal and written information?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. How often has your eating/weight reduced your ability to concentrate?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Financial:					
16. How often has your eating/weight led to problems with treatment provider(s) regarding cost of treatment?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. How often has your eating/weight led you to difficulty paying monthly bills?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. How often has your eating/weight resulted in significant financial debt?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. How often has your eating/weight led to the need to spend money from savings or use your credit card frequently?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. How often has your eating/weight resulted in the need to borrow money?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Work/School:					
21. How often has your eating/weight led to a leave of absence from work?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. How often has your eating/weight led to low grades?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. How often has your eating/weight resulted in reduced hours at work?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. How often has your eating/weight resulted in you losing a job or dropping out of school?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. How often has your eating/weight led to failure in a class or classes?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

BSQ-34

We should like to know how you have been feeling about your appearance over the **PAST FOUR WEEKS**. Please read each question and circle the appropriate number to the right. Please answer all the questions.

OVER THE PAST FOUR WEEKS:

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

Name _____

Date _____

The Berlin Questionnaire

Question	Response
Has your weight changed?	Increased Decreased No change
Do you snore?	Yes No Do not know
Snoring loudness	Loud as breathing Loud as talking Louder than talking Very loud
Snoring frequency	Almost every day 3 to 4 times per week 1 to 2 times per week 1 to 2 times per month Never or almost never
Does your snoring bother other people?	Yes or No
How often have your breathing pauses been noticed?	Almost everyday 3 to 4 times per week 1 to 2 times per week 1 to 2 times per month Never or almost never
Are you tired after sleeping?	Almost everyday 3 to 4 times per week 1 to 2 times per week 1 to 2 times per month Never or almost never
Are you tired during waketime?	Almost everyday 3 to 4 times per week 1 to 2 times per week 1 to 2 times per month Never or almost never
Have you ever fallen asleep while driving?	Yes or No
Do you have high blood pressure?	Yes or No Do not know

Mood Questionnaire

The questions you are about to answer will help your clinician provide a proper diagnosis. Please discuss the results of this questionnaire with your doctor.

Instructions for patients: Please check ONE BOX ONLY for each of the questions below.

The following three questions will ask you about a history of mania.*

- | | | |
|--|--------------------------|--------------------------|
| 1. Has there ever been a period of time when you were not your usual self and... | YES | NO |
| ...you felt so good or so hyper that other people thought you were not your normal self, or you were so hyper that you got into trouble? | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you were so irritable that you shouted at people or started fights or arguments? | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you felt much more self-confident than usual? | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you got much less sleep than usual and found you didn't really miss it? | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you were much more talkative and/or spoke much faster than usual? | <input type="checkbox"/> | <input type="checkbox"/> |
| ...thoughts raced through your head and/or you couldn't slow your mind down? | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you were so easily distracted by things around you that you had trouble concentrating or staying on track? | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you had much more energy than usual? | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you were much more active and/or did many more things than usual? | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you were much more social or outgoing than usual—for example, you telephoned friends in the middle of the night? | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you were much more interested in sex than usual? | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky? | <input type="checkbox"/> | <input type="checkbox"/> |
| ...spending money got you or your family into trouble? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | |
|--|--------------------------|--------------------------|
| 2. If you checked YES to more than one of the above, have you experienced several of these during the same period of time? | YES | NO |
| | <input type="checkbox"/> | <input type="checkbox"/> |

3. How much of a problem did any of these situations cause you (like being unable to work; having family, money, or legal problems; and/or getting into serious arguments or fights)?

No problem
 Minor problem
 Moderate problem
 Serious problem

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Two questions about yourself

These questions will ask you about current feelings of depression.

- | | | |
|--|--------------------------|--------------------------|
| 1. During the past month, have you often been bothered by feeling down, depressed, or hopeless? | YES | NO |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. During the past month, have you often been bothered by little interest or pleasure in doing things? | | |
| | <input type="checkbox"/> | <input type="checkbox"/> |

Social Phobia Inventory

Initials _____ Age _____ Sex _____ Date _____

ID# _____

Please check how much the following problems have bothered you during the past week.

Mark only one box for each problem, and be sure to answer all items.

	Not At All	A Little Bit	Somew hat	Very Much	Extremel y
1. I am afraid of people in authority.	0	1	2	3	4
2. I am bothered by blushing in front of people.	0	1	2	3	4
3. Parties and social events scare me.	0	1	2	3	4
4. I avoid talking to people I don't know.	0	1	2	3	4
5. Being criticized scares me a lot.	0	1	2	3	4
6. Fear of embarrassment causes me to avoid doing things or speaking to people.	0	1	2	3	4
7. Sweating in front of people causes me distress.	0	1	2	3	4
8. I avoid going to parties.	0	1	2	3	4
9. I avoid activities in which I am the center of attention.	0	1	2	3	4
10. Talking to strangers scares me.	0	1	2	3	4
11. I avoid having to give speeches.	0	1	2	3	4
12. I would do anything to avoid being criticized.	0	1	2	3	4
13. Heart palpitations bother me when I am around people.	0	1	2	3	4
14. I am afraid of doing things when people might be watching.	0	1	2	3	4
15. Being embarrassed or looking stupid are my worst fears.	0	1	2	3	4
16. I avoid speaking to anyone in authority.	0	1	2	3	4
17. Trembling or shaking in front of others is distressing to me.	0	1	2	3	4

From Connor K., Davidson J., Churchill L., Sherwood A., Foa E., Weister R., "Psychometric properties of the Social Phobia Inventory".

Br J Psychiatry. 2000; 176:379-86.

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Wender Utah Rating Scale for the Attention Deficit Hyperactivity Disorder

Overview:

The Wender Utah Rating Scale can be used to assess adults for Attention Deficit Hyperactivity Disorder with a subset of 25 questions associated with that diagnosis.

Wender Utah Rating Scale

- 61 questions answered by the adult patient recalling his or her childhood behavior
- 5 possible responses scored from 0 to 4 points

	As a child I was (or had):	not at all or very slightly	mildly	moderately	quite a bit	very much
1	active restless always on the go	0	1	2	3	4
2	afraid of things	0	1	2	3	4
3	concentration problems easily distracted	0	1	2	3	4
4	anxious worrying	0	1	2	3	4
5	nervous fidgety	0	1	2	3	4
6	inattentive daydreaming	0	1	2	3	4
7	hot- or short-tempered low boiling point	0	1	2	3	4
8	shy sensitive	0	1	2	3	4
9	temper outbursts tantrums	0	1	2	3	4
10	trouble with stick-to-it-tiveness not following through. failing to finish things started	0	1	2	3	4
11	stubborn strong-willed	0	1	2	3	4
12	sad or blue depressed unhappy	0	1	2	3	4
13	incautious. dare-devilish involved in pranks	0	1	2	3	4
14	not getting a kick out of things dissatisfied with life	0	1	2	3	4
15	disobedient with parents rebellious sassy	0	1	2	3	4
16	low opinion of myself	0	1	2	3	4

17	irritable	0	1	2	3	4
		not at all or very slightly	mildly	moder- ately	quite a bit	very much
18	outgoing friendly enjoyed company of people	0	1	2	3	4
19	sloppy disorganized	0	1	2	3	4
20	moody ups and downs	0	1	2	3	4
21	angry	0	1	2	3	4
22	friends popular	0	1	2	3	4
23	well-organized tidy neat	0	1	2	3	4
24	acting without thinking impulsive	0	1	2	3	4
25	tendency to be immature	0	1	2	3	4
26	guilty feelings regretful	0	1	2	3	4
27	losing control of myself	0	1	2	3	4
28	tendency to be or act irrational	0	1	2	3	4
29	unpopular with other children didn't keep friends for long didn't get along with other children	0	1	2	3	4
30	poorly coordinated did not participate in sports	0	1	2	3	4
31	afraid of losing control of self	0	1	2	3	4
32	well-coordinated picked first in games	0	1	2	3	4
33	tomboyish (for women only)	0	1	2	3	4
34	running away from home	0	1	2	3	4
35	getting into fights	0	1	2	3	4
36	teasing other children	0	1	2	3	4
37	leader bossy	0	1	2	3	4
38	difficulty getting awake	0	1	2	3	4
39	follower led around too much	0	1	2	3	4
40	trouble seeing things from	0	1	2	3	4

	someone else's point of view					
41	trouble with authorities trouble with school visits to principal's office	0	1	2	3	4
42	trouble with police booked convicted	0	1	2	3	4

	Medical problems as a child	not at all or very slightly	mildly	moder- ately	quite a bit	very much
43	headaches	0	1	2	3	4
44	stomachaches	0	1	2	3	4
45	constipation	0	1	2	3	4
46	diarrhea	0	1	2	3	4
47	food allergies	0	1	2	3	4
48	other allergies	0	1	2	3	4
49	bedwetting	0	1	2	3	4
	As a child in school I was (or had)	not at all or very slightly	mildly	moder- ately	quite a bit	very much
50	overall a good student fast	0	1	2	3	4
51	overall a poor student slow learner	0	1	2	3	4
52	slow in learning to read	0	1	2	3	4
53	slow reader	0	1	2	3	4
54	trouble reversing letters	0	1	2	3	4
55	problems with spelling	0	1	2	3	4
56	trouble with mathematics or numbers	0	1	2	3	4
57	bad handwriting	0	1	2	3	4
58	able to read pretty well but never really enjoyed reading	0	1	2	3	4
59	not achieving up to potential	0	1	2	3	4
60	repeating grades	0	1	2	3	4
61	suspended or expelled	0	1	2	3	4

EATING QUESTIONNAIRE

INSTRUCTIONS

The following questions are concerned with the PAST FOUR WEEKS ONLY (28 days). Please read each question carefully and circle the appropriate number on the right. Please answer ALL the questions.

On how many days out of the past 28 days.....	# days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	EVERY day
1) Have you been deliberately trying to limit the amount of food you eat to influence your shape or weight?	0	1	2	3	4	5	6
2) Have you gone for long periods of time (8 hrs or more) without eating anything in order to influence your shape or weight?	0	1	2	3	4	5	6
3) Have you tried to avoid eating any foods which you like in order to influence your shape or weight?	0	1	2	3	4	5	6
4) Have you tried to follow definite rules regarding your eating in order to influence your shape or weight; for ex: calorie limit, set amount of food, rules about what when you should eat?	0	1	2	3	4	5	6
5) Have you wanted your to be empty?	0	1	2	3	4	5	6
6) Has thinking about food or its calorie content made it much more difficult to concentrate on things you are interested in; ex: read watch TV, conversation?	0	1	2	3	4	5	6
7) Have you been afraid of losing control over eating?	0	1	2	3	4	5	6
8) Have you had episodes of binge eating?	0	1	2	3	4	5	6
9) Have you eaten in secret? Do not count binges.	0	1	2	3	4	5	6
10) Have you definitely wanted your stomach to be flat?	0	1	2	3	4	5	6
11) Has thinking about shape or weight made it more difficult to concentrate on things you are interested in; ex: read, TV, conversation?	0	1	2	3	4	5	6

25) Have you taken diuretics (water tablets) as a means of controlling you shape or weight?

0 – no

1 – yes []

26) How many times have you done this over the past 4 weeks? [] [] []

27) Have you exercised hard as a means of controlling your shape or weight?

0 – no

1 – yes []

28) How many time have you done this over the past 4 weeks? [] [] []

OVER THE PAST 4 WEEKS (28 DAYS)

PLEASE CIRCLE THE NUMBER WHICH BEST DESCRIBES YOUR BEHAVIOUR

29) Has your weight influenced how you think about (judge) yourself as a person?

<u>not at all</u>	<u>slightly</u>	<u>moderately</u>	<u>markedly</u>
0 1	2 3	4 5	5 6

30) Has your shape influenced how you think about (judge) yourself as a person?

<u>not at all</u>	<u>slightly</u>	<u>moderately</u>	<u>markedly</u>
0 1	2 3	4 5	5 6

31) How much would it upset you if you had to weigh yourself once a week for the next 4 weeks?

<u>not at all</u>	<u>slightly</u>	<u>moderately</u>	<u>markedly</u>
0 1	2 3	4 5	5 6

32) How dissatisfied have you felt about your weight?

<u>not at all</u>	<u>slightly</u>	<u>moderately</u>	<u>markedly</u>
0 1	2 3	4 5	5 6

33) How dissatisfied have you felt about your shape?

<u>not at all</u>	<u>slightly</u>	<u>moderately</u>	<u>markedly</u>
0 1	2 3	4 5	5 6

34) How concerned have you been about other people seeing you eat?

<u>not at all</u>	<u>slightly</u>	<u>moderately</u>	<u>markedly</u>
0 1	2 3	4 5	5 6

35) How uncomfortable have you felt seeing your body; ex: in the mirror, in shop window reflections, while undressing or taking a bath or shower?

<u>not at all</u>	<u>slightly</u>	<u>moderately</u>	<u>markedly</u>
0 1	2 3	4 5	5 6

36) How uncomfortable have you felt about others seeing your body; ex: in communal changing rooms, when swimming or wearing tight clothes?

<u>not at all</u>	<u>slightly</u>	<u>moderately</u>	<u>markedly</u>
0 1	2 3	4 5	5 6