

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

Pregnancy Test

Complete only for females.

Does participant have reproductive potential?

No

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

Results: Negative
 Positive

Outcomes Labs

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

| Sample | Sample Complete? | If Not Done, Reason (Use codelist below) | Staff Initials |
|---|--|---|---|
| <i>If a sample is not obtained, indicate with a Not Done.</i> | | | |
| Blood | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ | _____ <small>first middle last</small> |

Vaccine Administration

NOTE: Before any vaccine is administered, review the vaccine questionnaire and protocol for participant eligibility.

| Vaccine(s) given (check all that apply): | | If Not Done, Reason (Use codelist below) | Staff Initials |
|---|--|---|---|
| <input type="checkbox"/> Hepatitis A → Check one: <input type="checkbox"/> ₁ Havrix (GSK) <input type="checkbox"/> ₂ Vaqta (Merck) <input type="checkbox"/> ₉₈ Other: _____ Dose (check one): <input type="checkbox"/> ₁ Adult <input type="checkbox"/> ₂ Pediatric Lot #: _____ | | | |
| <input type="checkbox"/> Tetanus/diphtheria → Check one: <input type="checkbox"/> ₁ Decovac (Sanofi-Pasteur) <input type="checkbox"/> ₉₈ Other: _____ Lot #: _____ | | | _____ <small>first middle last</small> |
| <input type="checkbox"/> Pneumococcal vaccine → Check one: <input type="checkbox"/> ₁ Pneumovax (Merck) <input type="checkbox"/> ₉₈ Other: _____ Lot #: _____ | | | |

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

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

Clinic Weight

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

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: ____/____/____ 00:00 to 23:59
day month year

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: _____
first middle last

12-Lead ECG

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

Safety Labs

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

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

| Sample | Sample Complete? | If Not Done, Reason <small>(Use codelist below)</small> | 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> |

Outcomes Labs

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

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

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

If a sample is not obtained, indicate with a Not Done.

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 ____

Date completed: ____/____/____ 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 ____

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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

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 | Sometimes | 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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first middle last

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

| | Never | Very Rarely | Rarely | Some-times | 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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first middle last

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

| | Never | Very Rarely | Rarely | Sometimes | 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 |

Participant's Initials: _____
first middle last