**Appendix 1: Proposed Intake Questionnaire**

 **In the past month, how often did you drink water?**

|  |  |
| --- | --- |
| **Never/less than once a week** |  |
| **Several times/week** |  |
| **Once a day** |  |
| **Twice or more per day** |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  **Never** | **Sometimes** | **Every Day** |
| Eaten three meals per day? |  |  |  |
| Eaten fruit? |  |  |  |
| Eaten vegetables? |  |  |  |

**In the past month, how often have you. . .**

**Enter your lowest adult weight, in pounds:**

**At what age were you at your lowest adult weight, from above?**

**What was your approximate weight in pounds one year ago?**

**How many times have you seriously set out to lose weight?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Never** | **1-5 times** | **5-10 times** | **10-20 times** | * **20 times**
 |
|  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Strongly Agree** | **Agree Somewhat** | **Disagree** | **Doesn’t Apply** |
| I can never lose weight. |  |  |  |  |
| I have lost weight before, but I’ve gained it back eventually |  |  |  |  |
| I usually finish any diet I start |  |  |  |  |

**Please mark the most appropriate box, as it applies to you.**

|  |  |
| --- | --- |
| **Yes** | **No** |
|  |  |

**Have you experienced weight gain following a pregnancy?**

**If yes, how much?**

|  |  |  |  |
| --- | --- | --- | --- |
| **Pregnancy** | **Weight Gain** |  |  |
| **1** |  |  |  |
| **2** |  |  |  |
| **3** |  |  |  |
| **4** |  |  |  |
| **In the past when you have tried to lose weight, did you use any of the following?** |  |  |  |
|  | **Calorie Restriction** | **Exercise** | **Recovery Strategies** | **Medications** | **Other** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  **NO** |  **1-2** |  **>2** |
| **Are you taking any medications?** |  |  |  |
|  |  |  |  |

**If you’ve failed a diet in the past, would you say it was because of. . .**

|  |  |
| --- | --- |
| **Feeling Hungry** |  |
| **Feeling Tired** |  |
| **Feeling Depressed** |  |
| **Feeling like “it wasn’t worth it”** |  |
| **Feeling like you “just didn’t have time” for the program** |  |

|  |  |
| --- | --- |
| **Yes** | **No** |
|  |  |

**Have you ever changed your mind about wanting to be fit once starting a diet?**

**How interested would you be in losing weight if took 6 months?**

|  |  |  |  |
| --- | --- | --- | --- |
| **Very Interested** | **Somewhat Interested** | **Not Sure** | **6 months is too long** |
|  |  |  |  |

**How comfortable are you with exercise?**

|  |  |  |  |
| --- | --- | --- | --- |
| **Very Comfortable** | **Somewhat comfortable** | **Not Sure** | **Uncomfortable** |
|  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Demographic** **Information** |  |  |  |  |
|  | **Height (ft)** | **Height (in)** | **Weight (lbs)** | **Waist Circumference** |
|  |  |  |  |  |
|  | **Age** | **Number of Overweight Parents** | **Number of Medical Diseases** | **Years of Athletic Experience** |
|  |  |  |  |  |