Holyoke Medical Center

HMC Weight Management Program

Name: _____ **DOB:** _____

Please list any medical conditions you have ever been diagnosed with:

Please list ALL surgical procedures that you have had, including colonoscopy, EGD, oral surgery, etc.:

Please list ALL of your current medications (prescribed and over the counter, including supplements, vitamins, herbal, and birth control). Please include dosage and frequency you take them (i.e., daily, twice a day, every 8 hours, etc.):
(Attach a list if needed)

11 Hospital Drive, Holyoke, MA 01040 • (413) 535-4757 • Fax (413) 535-4758
HolyokeHealth.com
A member of Valley Health Systems, Inc.

Holyoke Medical Center

HMC Weight Management Program

Weight Management Program (WMP) Cancellation and No show Policy

In order to keep our program running efficiently and to make sure that patients have their follow up appointments in a timely manner we have developed a cancellation and no show policy. We understand that there may be times that you will need to cancel and reschedule an appointment, please follow the instructions below to make sure that this will not jeopardize your participation in our program.

You will receive a call from one of our staff before all of your appointments in our office.
PLEASE FOLLOW THE INSTRUCTIONS TO CONFIRM YOUR APPOINTMENT.
If you do not confirm your appointment, this appointment time may be given to another patient from our wait list.

IF YOU NEED TO CANCEL YOUR APPOINTMENT-You must call the office at least 24 hours before your appointment time to inform us. If we do not hear from you, or if you are more than 15 minutes late you will be considered a “no show”.

If you have multiple no shows, the bariatric team will determine whether you will have access to subsequent appointments in our department.

My signature below signifies that I have read and understand the WMP’s cancelation and No Show policies and I agree to comply with them.

SIGNATURE: _____

DATE: _____

January 2022

Behavioral Health Services in the Weight Management Program

I understand that as part of my initial and ongoing weight management treatment I will be evaluated by a Behavioral Health provider who will assess my initial and ongoing psychological readiness and perioperative progress and psychological and behavioral needs. I understand that the records of my Behavioral Health sessions, maintained in a confidential manner, will be available to the Weight Management team and will consent to disclosure of same. I understand that I may need to participate in more intensive psychological counseling and therapy to maximize my overall wellness and weight loss goals and that my consent will be required to disclose the content of those conversations.

By voluntarily signing this document, I confirm that I have read and agree with the above program requirement.

Name_____ Date _____

EFFORTS AT WEIGHTLOSS

NAME: _____ DATE: _____

What type(s) of diet(s), if any, have you followed in the past?
Please give approximate dates and be very thorough.

Diet/Methods	**Start Date**	**End Date**	**Weight Lost**	**Wgt Regained**
Diminishing Dimensions				
Jenny Craig				
NutriSystems				
TOPS (Take Off Pounds Sensibly)				
Weight Watchers				
Overeaters Anonymous				
Liquid / Protein Diet *Specify*:				
Other commercial weight loss program(s):				
Over the Counter Diet Pills				
Prescription Diet Pills *Specify*:				
Medically Supervised				
Registered Dietician				
Alternative Medicine: (acupuncture, hypnosis, naturopathic doctor) *Specify*:				
Surgical Intervention: (gastric bypass, liposuction, wired jaw) *Specify*:				
Fad Diets: (Atkins, Blood Type Diet, Cabbage Soup, Grapefruit Diet, South Beach, Sugar Busters, The Zone, Keto, etc.) *Specify*:				
Others: *(Please specify)*				

Weight Trend in the Past 5 Years

Current Year: _____ Weight: _____
Year: _____ Weight: _____
Year: _____ Weight: _____
Year: _____ Weight: _____
Year: _____ Weight: _____

Please Circle All Positive Responses

Excessive tiredness

Fever

Headache

Lightheadedness

Interrupted sleep

Difficulty falling asleep

Snoring

Stop breathing during sleep

Difficulty swallowing

Irregular menses

Excessive thirst

Cough

Shortness of breath

Shortness of breath with simple tasks

Wheezing

Chest pain

Irregular heart beat

Leg swelling

Stomach ulcer

Acid reflux

Blood in stool

Constipation

Diarrhea

Exposure to hepatitis

Nausea

Vomiting

Easy bruising

Prolong bleeding

Loss of urine with coughing or laughing

Kidney stones

Back pain

Knee pain

Shoulder pain

Skin rashes

Loss of strength

Anxiety

Depression

Thoughts of hurting yourself

Adverse Childhood Experience (ACE) Questionnaire

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often**… Swear at you, insult you, put you down, or humiliate you? **or** Act in a way that made you afraid that you might be physically hurt?	If yes, enter 1 _____
2. Did a parent or other adult in the household **often**… Push, grab, slap, or throw something at you? **or** Ever hit you so hard that you had marks or were injured?	If yes, enter 1 _____
3. Did an adult or person at least 5 years older than you **ever**… Touch or fondle you or have you touch their body in a sexual way? **or** Try to or actually have oral, anal, or vaginal sex with you?	If yes, enter 1 _____
4. Did you **often** feel that… No one in your family loved you or thought you were important or special? **or** Your family didn't look out for each other, feel close to each other, or support each other?	If yes, enter 1 _____
5. Did you **often** feel that… You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **or** Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	If yes, enter 1 _____
6. Were your parents **ever** separated or divorced?	If yes, enter 1 _____
7. Was your mother or stepmother: **Often** pushed, grabbed, slapped, or had something thrown at her? **or** **Sometimes or often** kicked, bitten, hit with a fist, or hit with something hard? **or** **Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?	If yes, enter 1 _____
8. Did you live with anyone who was a problem drinker or alcoholic or who used drugs?	If yes, enter 1 _____
9. Was a household member depressed or mentally ill or did a household member attempt suicide?	If yes, enter 1 _____
10. Did a household member go to prison?	If yes, enter 1 _____

Now, add up your "Yes" answers: _____ This is your ACE Score

Epworth Sleepiness Scale (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would affect you. Use the following scale to choose the ***most appropriate number*** for each situation:

0 = would never dose

1 = ***slight*** chance of dozing

2 = ***moderate*** chance of dozing

3 = ***high*** chance of dosing

Situation	**Chance of dozing 0 – 3**
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting inactive in a theater, movie, etc.	_____
4. As a passenger in a car for an hour without break	_____
5. Lying down in the afternoon when circumstances permit	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after lunch without alcohol	_____
8. In a car, while stopped for a few minutes in traffic	_____
TOTAL:	_____

ESS < 10: normal, ESS > 12: pathologic

Gastroesophageal Reflux Disease (GERD)

Have you been diagnosed with reflux (GERD)? ☐ YES ☐ NO

What medications do you take for reflux? _____

_____

Questions about symptoms ***(circle one for each question)***	**Scale**					
How bad is the heartburn?	0	1	2	3	4	5
Heartburn when lying down?	0	1	2	3	4	5
Heartburn when standing up?	0	1	2	3	4	5
Heartburn after meals?	0	1	2	3	4	5
Does heartburn change your diet?	0	1	2	3	4	5
Does heartburn wake you up from sleep?	0	1	2	3	4	5
Do you have difficulty swallowing?	0	1	2	3	4	5
Do you have pain with swallowing?	0	1	2	3	4	5
If you take medicine for your reflux, does this affect your daily life?	0	1	2	3	4	5
Satisfaction with present condition	Satisfied			Not satisfied		
Total score:						

0 = no symptoms

1 = symptoms noticeable, but not bothersome (slight/occasional),

2 = symptoms noticeable and bothersome, but not daily,

3 = symptoms bothersome every day,

4 = symptoms affect daily activities,

5 = symptoms are incapacitating – unable to do daily activities.

Impact of Weight on Quality of Life Questionnaire—Lite Version (IWQOL-Lite)

Please answer the following statements by circling the number that best applies to you *in the past week*. Be as open as possible. There are no right or wrong answers.

Physical Function		Always True	Usually True	Sometimes True	Rarely True	Never True
1.	Because of my weight, I have trouble picking up objects.	5	4	3	2	1
2.	Because of my weight, I have trouble tying my shoes.	5	4	3	2	1
3.	Because of my weight, I have difficulty getting up from chairs.	5	4	3	2	1
4.	Because of my weight, I have trouble using stairs.	5	4	3	2	1
5.	Because of my weight, I have difficulty putting on or taking off my clothing.	5	4	3	2	1
6.	Because of my weight, I have trouble with mobility.	5	4	3	2	1
7.	Because of my weight, I have trouble crossing my legs.	5	4	3	2	1
8.	I feel short of breath with only mild exertion.	5	4	3	2	1
9.	I am troubled by painful or stiff joints.	5	4	3	2	1
10.	My ankles and lower legs are swollen at the end of the day.	5	4	3	2	1
11.	I am worried about my health.	5	4	3	2	1
	Total:					

Self-esteem		Always True	Usually True	Sometimes True	Rarely True	Never True
1.	Because of my weight, I am self-conscious.	5	4	3	2	1
2.	Because of my weight, my self-esteem is not what it could be.	5	4	3	2	1
3.	Because of my weight, I feel unsure of myself.	5	4	3	2	1
4.	Because of my weight, I do not like myself.	5	4	3	2	1
5.	Because of my weight, I am afraid of being rejected.	5	4	3	2	1
6.	Because of my weight, I avoid looking in mirrors or seeing myself in photographs.	5	4	3	2	1
7.	Because of my weight, I am embarrassed to be seen in public places.	5	4	3	2	1
	Total:					

Sexual Life		Always True	Usually True	Sometimes True	Rarely True	Never True
1.	Because of my weight, I do not enjoy sexual activity.	5	4	3	2	1
2.	Because of my weight, I have little or no sexual desire.	5	4	3	2	1
3.	Because of my weight, I have difficulty with sexual performance.	5	4	3	2	1
4.	Because of my weight, I avoid sexual encounters whenever possible.	5	4	3	2	1
	Total:					

Public Distress		Always True	Usually True	Sometimes True	Rarely True	Never True
1.	Because of my weight, I experience ridicule, teasing, or unwanted attention.	5	4	3	2	1
2.	Because of my weight, I worry about fitting into seats in public places (e.g. theaters, restaurants, cars, or airplanes).	5	4	3	2	1
3.	Because of my weight, I worry about fitting through aisles or turnstiles.	5	4	3	2	1
4.	Because of my weight, I worry about finding chairs that are strong enough to hold my weight.	5	4	3	2	1
5.	Because of my weight, I experience discrimination by others.	5	4	3	2	1
	Total:					

Work *(Note: For homemakers and retirees, answer with respect to your daily activities.)*		Always True	Usually True	Sometimes True	Rarely True	Never True
1.	Because of my weight, I have trouble getting things accomplished or meeting my responsibilities.	5	4	3	2	1
2.	Because of my weight, I am less productive than I could be.	5	4	3	2	1
3.	Because of my weight, I don't receive appropriate raises, promotions or recognition at work.	5	4	3	2	1
4.	Because of my weight, I am afraid to go on job interviews.	5	4	3	2	1
	Total:					

Grand Total _____

CONSENT TO ACT AS A PARTICIPANT IN THE BARIATRIC REGISTRY

TITLE: Bariatric Registry at Holyoke Medical Center

PRINCIPAL INVESTIGATOR: **Ioannis Raftopoulos, MD**
Director, Weight Management program
Holyoke Medical Center
10 Hospital Drive, Suite 103
Holyoke, MA 01040
Telephone: (413) 535-2837

SOURCE OF SUPPORT: None

What is the purpose of this Research Registry?

Many advancements in medicine have resulted from research involving the collection and analysis of the medical record information of patients with a certain disease or condition. Because you are being seen by the Weight Management program at Holyoke Medical Center, we are asking for your permission to allow us to place your past, current and future medical record **deidentified (anonymous)** information into a Bariatric Registry (Database). By placing the medical record information of many patients such as you into a registry, we will be able to conduct studies directed at increasing our knowledge about Surgical Weight Loss.

It is anticipated that the Bariatric Registry will assist our bariatric surgeons in two important ways.

First, it will allow our surgeons to review and study the medical records of many individuals to answer questions about your disease and its treatment.

Second, it will help our Bariatric program identify and recruit patients who are eligible for participation in future studies unrelated to this Bariatric Registry. For example, our physicians associated with the Weight Management program at Holyoke Medical Center are also frequently involved in studies directed at evaluating the safety and

effectiveness of drugs, devices or procedures related to Weight Loss. If you agree to participate in this Bariatric Registry, your medical record information will be reviewed by our physicians only to determine if you might qualify for various future research studies. Participation in these future studies will not be automatic but it will occur only if you agree to participate.

Who is being asked to participate in this Bariatric Registry?

All adult (age ≥ 18 years old) patients or adolescents (12-18 years old) who are seeking treatment or are being treated at the Weight Management program at Holyoke Medical Center are being asked to participate in this Bariatric Registry.

What will my participation in this Bariatric Registry involve?

If you agree to participate in the Bariatric Registry, your past, current, and future medical record information will be placed **anonymously** into the Bariatric Registry. This will permit studies to be conducted on the medical record information contained within the registry. You are being asked to allow us to contact you if one of our bariatric surgeons determines, through review of your medical record information contained in the Bariatric Registry that you are eligible for participation in a future study directed at the study of Weight Loss. Please note that if you qualify for any future research studies, which are unrelated to the information placed in this Bariatric Registry, you will be asked to sign a separate consent form that outlines in detail the nature of this research study, including its potential risks and benefits.

What are the possible risks of my participation in the Bariatric Registry?

There are no risks of physical injury associated with your participation in the Bariatric Registry. Participation in this Bariatric Registry does involve the remote possible risk that information about your health might become known to individuals outside of the Weight Management program at Holyoke Medical Center.

We will attempt to preserve your medical record confidentiality by assigning a special research code number to your medical record information stored in the Bariatric Registry, and by removing personal identifiers (for example, your name, social security number, medical record number) from information stored about you in the Bariatric Registry. Information linking the research code number to your name and other personal identifiers will be stored in a separate secure location. Access to any identifiable information about you that is contained within the Bariatric Registry will be limited to the investigators associated with our Weight Management program Registry.

What are the possible benefits of my participation in the Bariatric Registry?

It is unlikely that you will receive any direct benefit as a result of your participation in the Bariatric Registry.

However, medical record information contained within the Bariatric Registry will be used for studies directed at improving our knowledge and treatment of Weight Loss and this knowledge may benefit patients for Weight Loss in the future.

Will I or my insurance provider be charged for my participation in the Bariatric Registry?

There will be no costs to you or your insurance provider to participate in this Bariatric Registry.

Will I be paid for my participation in the Bariatric Registry?

No, you will not receive any payment for participating in this Bariatric Registry.

Who will know about my participation in this Bariatric Registry?

Any information from your medical records that is placed into this Bariatric Registry will be kept as confidential (private) as possible. In addition, you will not be identified by name in any publication of the results of research studies involving the use of your medical record information unless you sign a separate consent form (release) giving your permission.

Some of your data will be shared with the American Society of Metabolic and Bariatric Surgery as part of our mandatory Center of Excellence outcome reporting requirements. All data will be de-identified prior to submission.

What is the nature of my medical record information that will be placed into the Bariatric Registry?

All of your past, current and future medical record information related to your Weight Loss will be recorded into the Bariatric Registry. Since medical conditions and treatments not related directly to your Weight Loss may affect Weight Loss and/or its treatment, it is likely that all of your existing and future medical record information

will be placed in the Bariatric Registry. This information will be collected from your Bariatric Center records, hospital records and, if applicable, private physician records.

Who will have access to my identifiable medical record information contained in the Bariatric Registry?

Access to your identifiable medical record information contained within this Bariatric Registry will be limited to Weight Management investigators. A current, complete listing of these individuals will be provided to you upon your written request.

In addition, the Weight Management investigators may have access to your identifiable medical record information contained within this Bariatric Registry.

Authorized representatives of Holyoke Medical Center Institutional Review Board may review information contained within the Bariatric Registry to ensure that the Bariatric Registry adequately protects your privacy.

In unusual cases, the researchers may be required to release your identifiable medical record information from the Bariatric Registry in response to an order from a court of law.

For how long will my medical record information continue to be placed in the Bariatric Registry and for how long will this information be used for research purposes?

We will continue to place your medical record information into the Bariatric Registry until 1) you are no longer living; or 2) you withdraw your permission for participation in the Bariatric Registry.

Your medical record information contained within the Bariatric Registry will be used for research purposes for an indefinite period of time.

Is my participation in the Bariatric Registry voluntary?

Your participation in the Bariatric Registry, to include the use of your medical record information for the research purposes described above, is completely voluntary. Whether or not you provide your permission for participation in this Bariatric Registry will have no affect on your current or future medical care at Holyoke Medical Center, affiliated health care provider, or your current or future relationship with a health care insurance provider. Whether or not you provide your permission for participation in

this Bariatric Registry will have no affect on your current or future relationship with Holyoke Medical Center.

May I withdraw, at a future date, my consent for participation in this Bariatric Registry?

You may withdraw, at any time, your consent for participation in the Bariatric Registry, to include the additional collection of your medical record information and its further use for the research purposes described above. However, any research use of your medical record information prior to the date that you formally withdraw your permission will not be destroyed.

To formally withdraw your permission for participation in the Bariatric Registry you should provide a written and dated notice of this decision to the principal investigator of the Bariatric Registry at the address listed on the first page of this consent form.

****

VOLUNTARY CONSENT

All of the above has been explained to me and all of my current questions have been answered. I understand that I am encouraged to ask questions about any aspect of my participation in the Bariatric Registry at any time, and that such future questions will be answered by the physicians associated with the Weight Management program or their staffs. I understand that a copy of this consent form will be given to me.

I understand that any questions which I have about my rights as a participant in the Bariatric Registry will be answered by the Institutional Review Board, Holyoke Medical Center, 575 Beech Street, Holyoke, MA 01040; (413) 534-2578.

By signing below, I agree to participate in the Bariatric Registry.

_____
Printed Name of Participant

_____ _____
Participant's Signature Date

My parents and Weight Management investigators have talked to me about being part of the Bariatric Registry. I understand the reason for the collection of my medical record information. I know that I can ask questions about the Bariatric Registry at any time. I also know that I can decide not to have my information included in the Bariatric Registry, or after signing this form I can decide that I no longer what my information to be used. Whatever I decide to do, I know my parents, doctors, and others who care for me will not be angry with me and will continue to care for me.

_____
Printed Name of Child

_____ _____
Child's Signature Date

_____ _____
Parent/Guardian Signature Date

CERTIFICATION OF INFORMED CONSENT

I certify that I have explained the nature and purpose of the Bariatric Registry to the above-named individual, and I have discussed the possible risks and potential benefits of participation in this Bariatric Registry. Any questions the individual has about this Bariatric Registry have been answered, and the physician and staff associated with the Weight Management program will be available to address future questions as they arise.

_____
Printed Name of Person Obtaining Consent

_____ _____
Signature of Person Obtaining Consent Date

Holyoke Medical Center
HMC Weight Management Program

Behavioral Health Intake Paperwork

As part of our program you will meet with our licensed mental health clinician, Maria Michelakis Cintron. The following documents will be used for your visit with Maria:

- PHQ-9 Patient Health Questionnaire
- Binge Eating Scale
- Consent to release information

The first two will be used as part of assessing your readiness for surgery. The consent is if you have another therapist, psychiatrist or provider that you would like Maria be able to contact. Please make sure to complete these and return them before your appointment. Thank you for your continued participation to ensure that we're able to provide you with the best care.

Best regards,

HMC Weight Management Team

11 Hospital Drive Holyoke, MA 01040 • (413) 535-4757 • Fax (413) 535-4758
HolyokeHealth.com
A member of Valley Health Systems, Inc.

PATIENT NAME: _____ DATE OF BIRTH: _____

MEDICAL RECORD NUMBER: _____ PHONE #: _____

RELEASE FROM HOLYOKE MEDICAL CENTER (HMC): I authorize HMC to release my health information to:

Name: _____

Address: _____

What to Release: *Dates of Service:* _____

Please include the following information: ☐ Entire Record, ***OR*** the following (check all that apply)

- ☐ Abstract (Provider notes, test results)
- ☐ Lab results ☐ Pathology Reports
- ☐ Radiology Reports (X-Ray, MRI CT) ☐ Films
- ☐ Cardiology / EKG Reports
- ☐ Discharge Summary ☐ Other _____
- ☐ Operative Reports
- ☐ Work Connection (OHS / OHC / EHP)
- ☐ Behavioral Health
- ☐ Inpatient ☐ PHP / IOP ☐ Outpatient

Purpose of Request: ☐ Continuity of Care ☐ Legal ☐ Personal ☐ Other: _____

RELEASE TO HMC: I authorize _____ to release my health information to:

Holyoke Medical Center, Attention Dept. _____ 575 Beech St., Holyoke, MA 01040 FAX: 413-534-2618

What to Release: Dates of Service: _____

Please include the following information:

- ☐ Abstract (Provider notes, test results)
- ☐ Discharge/Transfer Summary
- ☐ Radiology Reports ☐ Films
- ☐ Operative Reports ☐ Laboratory & Pathology Reports
- ☐ Behavioral Health
- ☐ Psychosocial Assessment ☐ Medication Management Information
- ☐ Treatment Plan/Progress ☐ Presence/Progress/Participation Treatment
- ☐ Admission & Discharge note for hospitalization (dates) _____
- ☐ Other _____
- ☐ Other _____

Purpose of Request: ☐ Continuity of Care ☐ Legal ☐ Personal ☐ Other: _____

RELEASE OF PRIVILEGED INFORMATION:

_____ (Initials) **HIV/AIDS:** I hereby authorize release of protected health information pertaining to HIV testing and/or diagnosis and/or treatment related to Acquired Immune Deficiency Syndrome (AIDS) only to the person or organization named above and only for the purpose name above.

_____ (Initials) **GENETIC TESTING:** I hereby authorize release of protected health information pertaining to genetic test results only to the person or organization named above and only for the purpose name above.

_____ (Initials) **ALCOHOL and DRUG TREATMENT:** I hereby authorize release of treatment records of a licensed drug and alcohol treatment program to the person or organization named above and only for the purpose name above. I also understand that my Alcohol and Drug Abuse Records cannot be re-disclosed without my express authorization.

_____ (Initials) **INPATIENT PSYCHIATRIC RECORDS OR RECORDS OF A PSYCHOLOGIST OR PSYCHOTHERAPIST:** I hereby authorize release of psychiatric treatment records, and/or records of a psychologist or psychotherapist only to the person or organization named above and only for the purpose name above.

_____ Domestic violence abuse counselor records **_____ Social service records** **_____ Sexual assault counselor records**
_____ Sexually transmitted disease records

INDIVIDUAL RIGHTS: I understand the following:

- I have the right to revoke this authorization at any time.
- If I revoke this authorization I must do so in writing to the attention of the Medical Records Dept, HMC, 575 Beech St., Holyoke, MA 01040, or must contact the party whom I had authorized to release the information, if other than HMC.
- My right to revoke does not apply to information already released on the basis of this authorization.
- The privacy of my health records is protected under "HIPAA," 45 CFR, pts 160 & 164, and the privacy of any alcohol and/or drug treatment records are also protected under the Federal Confidentiality & Drug Abuse Records regulations, 42 CFR, pt 2.
- I understand that Holyoke Medical Center cannot guarantee that the Recipient will not re-disclose my health information to anyone else.
- There may be a charge for providing copies of medical records.

Expiration Date: This authorization will expire in one year unless revoked or otherwise specified to be the following date, event or condition:

(person's initials) _____ Conclusion of this Treatment Episode (person's initials) _____ Other: _____

Signature: _____ *Date:* _____

If not signed by person served, specify relationship: ☐ Parent ☐ Legal Guardian/Designee

Holyoke Medical Center

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

The PHQ-9 is the 9-item depression module from the full The Patient Health Questionnaire (PHQ which is designed to be entirely self-administered by a patient.

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not At All	Several Days	More Than Half The Days	Nearly Every Day
1. Little interest or pleasure in doing things.	○	○	○	○
2. Feeling down, depressed or hopeless.	○	○	○	○
3. Trouble falling asleep, staying asleep, or sleeping too much.	○	○	○	○
4. Feeling tired or having little energy.	○	○	○	○
5. Poor appetite or overeating.	○	○	○	○
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down.	○	○	○	○
7. Trouble concentrating on things, such as reading the newspaper or watching television.	○	○	○	○
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual.	○	○	○	○
9. Thoughts that you would be better off dead or of hurting yourself in some way.	○	○	○	○

The BES is a 16-item questionnaire assessing the presence of certain binge eating behaviors which may be indicative of an eating disorder.

Below are groups of statements about behavior, thoughts, and emotional states. Please indicate which statement in each group **best describes how you feel**.

1.

- ○ I don't feel self-conscious about my weight or body size when I'm with others.
- ○ I feel concerned about how I look to others, but it normally does not make me feel disappointed with myself.
- ○ I do get self-conscious about my appearance and weight which makes me feel disappointed in myself.
- ○ I feel very self-conscious about my weight and frequently, I feel intense shame and disgust for myself. I try to avoid social contacts because of my self-consciousness.

2.

- ○ I don't have any difficulty eating slowly in the proper manner.
- ○ Although I seem to "gobble down" foods, I don't end up feeling stuffed because of eating too much.
- ○ At times, I tend to eat quickly and then, I feel uncomfortably full afterwards.
- ○ I have the habit of bolting down my food, without really chewing it. When this happens I usually feel uncomfortably stuffed because I've eaten too much.

3.

- ○ I feel capable to control my eating urges when I want to.
- ○ I feel like I have failed to control my eating more than the average person.
- ○ I feel utterly helpless when it comes to feeling in control of my eating urges.
- ○ Because I feel so helpless about controlling my eating I have become very desperate about trying to get in control.

4.

- ○ I don't have the habit of eating when I'm bored.
- ○ I sometimes eat when I'm bored, but often I'm able to "get busy" and get my mind off food.
- ○ I have a regular habit of eating when I'm bored, but occasionally, I can use some other activity to get my mind off eating.
- ○ I have a strong habit of eating when I'm bored. Nothing seems to help me break the habit.

5.

- ○ I'm usually physically hungry when I eat something.
- ○ Occasionally, I eat something on impulse even though I really am not hungry.
- ○ I have the regular habit of eating foods, that I might not really enjoy, to satisfy a hungry feeling even though physically, I don't need the food.

- ○ Although I'm not physically hungry, I get a hungry feeling in my mouth that only seems to be satisfied when I eat a food, like a sandwich, that fills my mouth. Sometimes, when I eat the food to satisfy my mouth hunger, I then spit the food out so I won't gain weight.

6.

- ○ I don't feel any guilt or self-hate after I overeat.
- ○ After I overeat, occasionally I feel guilt or self-hate.
- ○ Almost all the time I experience strong guilt or self-hate after I overeat.

7.

- ○ I don't lose total control of my eating when dieting even after periods when I overeat.
- ○ Sometimes when I eat a "forbidden food" on a diet, I feel like I "blew it" and eat even more.
- ○ Frequently, I have the habit of saying to myself, "I've blown it now, why not go all the way" when I overeat on a diet. When that happens I eat even more.
- ○ I have a regular habit of starting strict diets for myself, but I break the diets by going on an eating binge. My life seems to be either a "feast" or "famine."

8.

- ○ I rarely eat so much food that I feel uncomfortably stuffed afterwards.
- ○ Usually about once a month, I eat such a quantity of food, I end up feeling very stuffed.
- ○ I have regular periods during the month when I eat large amounts of food, either at mealtime or at snacks.
- ○ I eat so much food that I regularly feel quite uncomfortable after eating and sometimes a bit nauseous.

9.

- ○ My level of calorie intake does not go up very high or go down very low on a regular basis.
- ○ Sometimes after I overeat, I will try to reduce my caloric intake to almost nothing to compensate for the excess calories I've eaten.
- ○ I have a regular habit of overeating during the night. It seems that my routine is not to be hungry in the morning but overeat in the evening.
- ○ In my adult years, I have had week-long periods where I practically starve myself. This follows periods when I overeat. It seems I live a life of either "feast or famine."

10.

- ○ I usually am able to stop eating when I want to. I know when "enough is enough."
- ○ Every so often, I experience a compulsion to eat which I can't seem to control.
- ○ Frequently, I experience strong urges to eat which I seem unable to control, but at other times I can control my eating urges.
- ○ I feel incapable of controlling urges to eat. I have a fear of not being able to stop eating voluntarily.

11.

- ○ I don't have any problem stopping eating when I feel full.
- ○ I usually can stop eating when I feel full but occasionally overeat leaving me feeling uncomfortably stuffed.
- ○ I have a problem stopping eating once I start and usually I feel uncomfortably stuffed after I eat a meal.
- ○ Because I have a problem not being able to stop eating when I want, I sometimes have to induce vomiting to relieve my stuffed feeling.

12.

- ○ I seem to eat just as much when I'm with others (family, social gatherings) as when I'm by myself.
- ○ Sometimes, when I'm with other persons, I don't eat as much as I want to eat because I'm self-conscious about my eating.
- ○ Frequently, I eat only a small amount of food when others are present, because I'm very embarrassed about my eating.
- ○ I feel so ashamed about overeating that I pick times to overeat when I know no one will see me. I feel like a "closet eater."

13.

- ○ I eat three meals a day with only an occasional between meal snack.
- ○ I eat 3 meals a day, but I also normally snack between meals.
- ○ When I am snacking heavily, I get in the habit of skipping regular meals.
- ○ There are regular periods when I seem to be continually eating, with no planned meals.

14.

- ○ I don't think much about trying to control unwanted eating urges.
- ○ At least some of the time, I feel my thoughts are pre-occupied with trying to control my eating urges.
- ○ I feel that frequently I spend much time thinking about how much I ate or about trying not to eat anymore.
- ○ It seems to me that most of my waking hours are pre-occupied by thoughts about eating or not eating. I feel like I'm constantly struggling not to eat.

15.

- ○ I don't think about food a great deal.
- ○ I have strong cravings for food but they last only for brief periods of time.
- ○ I have days when I can't seem to think about anything else but food.
- ○ Most of my days seem to be pre-occupied with thoughts about food. I feel like I live to eat.

16.

- ○ I usually know whether or not I'm physically hungry. I take the right portion of food to satisfy me.
- ○ Occasionally, I feel uncertain about knowing whether or not I'm physically hungry. At these times it's hard to know how much food I should take to satisfy me.
- ○ Even though I might know how many calories I should eat, I don't have any idea what is a "normal" amount of food for me.