NAME: DATE:

The Epworth Sleepiness Scale (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 have affected you. Use the following scale to choose the most appropriate number for each situation.

0= would ***never*** doze
1= ***slightly*** chance of dozing
2= ***moderate*** chance of dozing
3= ***high*** chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	
Watch television	
Sitting inactive in a public place(e.g. theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and taking to someone	
Sitting quietly after a lunch with alcohol	
In a car, while stopped for a few minutes in the traffic	
TOTAL SCORE	

SCORE RESULTS:

1-6	Congratulations, you are getting enough sleep!
7-8	Your score is average
9 and up	Very sleepy and should seek medical advice

NAME: DATE:

DIETING HISTORY:

Age you first started dieting:_____ **Approximate weight at age 18:**_____

Height: _____ Current Weight: _____ **BMI _____**

Weight range last 5 years (lbs.) _____ to _____

Program	Yes	No	Date(s)	Duration	Max loss	Doctor Supervised?
Nutri-systems						
Weight watchers						
Fen/Phen Raductil						
Meridia						
Xenical						
Other diet aids						

What was the most successful weight loss you have achieved and how did you do it?

_____

_____

What behaviors did you learn from dieting that you still use today?

_____

_____

_____

NAME: DATE:

FOOD PREFERENCE:

Do you eat sweets? Yes No **If yes, what**?_____

How often?_____

Do you eat pasta/bread? Yes No **If so, what?** _____

How often? _____

Do you eat fast food? Yes No **If so, what**?_____

How often? _____

Do you snack between meals? Yes No **If so, what do you snack on?** _____

How often?_____

Is snacking from habit? Yes No **Boredom?** Yes No

Do you binge eat? Yes No **If so, how often?** _____

What Beverages do you consume throughout the day? _____

Quantity? _____

SOCIAL / FAMILY HISTORY:

Is there Obesity in the family? Yes No If so, **Who?** _____

Do you exercise regularly? Yes No **If so, what do you do:**_____

Exercise Frequency? _____ **Duration?** _____

What restrictions keep you from exercising? _____

Have you ever had to deal with abuse? (Emotional, physical, mental or substance abuse).

Describe your present life stressors: