Weight and Lifestyle Inventory (WALI)

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Please be sure to complete both sides of each page.

Modified for Use by Perkins Counseling & Psychological Services, PLLC

The Weight and Lifestyle Inventory may be cited as: Wadden TA, Foster GD. The Weight and Lifestyle Inventory (WALI). Obesity. 2006;14(Suppl 2):99S–118S. Information concerning use of the Weight and Lifestyle Inventory may be obtained from Thomas A. Wadden, Weight and Eating Disorders Program, University of Pennsylvania School of Medicine, 3535 Market Street, Suite 3029, Philadelphia, PA 19104. E-mail: wadden@mail.med.upenn.edu

The WALI is designed to assess your weight and dieting histories, your eating and exercise habits, and your relationships with family and friends. Please complete the questionnaire carefully and make your best guess when unsure of an answer. You will have an opportunity to review your answers with our professional staff during your session. Please be assured that your information will be kept confidential and will only be available to the treatment staff.

Please allow 45-60 minutes to complete this questionnaire. Thank you for taking the time to complete this questionnaire. We look forward to helping you achieve your healthier lifestyle goals.

SECTION A: IDENTIFYING INFORMATION

Name: Today's Date:

Date of Birth: Age: Weight: lbs. Height: ft. in.

Address:

Phone: Day- Evening- Occupation:

Years at job:

Highest year of school completed: High School ☐ College 1☐ 2☐ 3☐ 4☐ Masters ☐

Doctorate ☐

Ethnicity (Check all that apply): American Indian ☐ Asian ☐ African American ☐

Hispanic ☐ White ☐ Other:

How did you hear about our program? ☐ Newspaper ☐ Physician ☐ Friend ☐ Other

Professional ☐Employer ☐Website ☐ Other (Please specify

)

SECTION B: WEIGHT HISTORY

1. At what age were you first overweight by 10 lbs or more? years old
   How do you remember that you were overweight at this time? (e.g. pictures, clothes size, others telling you)

2. What has been your highest weight after age 21? lbs., yrs. old

3. What has been your lowest weight (not due to illness) after age 21, which you maintained for at least 1 year? lbs. yrs. old, maintained for yrs.
   Was this weight reached after a weight loss effort? Yes ☐ No ☐

4. Check the statement number below that best describes you. "During the past 6 months my weight has..."
   1. decreased more than 10 lbs. ☐ 4. increased by 5 to 10 lbs. ☐
   2. decreased 5 to 10 lbs. ☐ 5. increased more than 10 lbs. ☐

3. been relatively stable. ☐

5. For each time period shown below, please list your maximum weight. If you cannot remember what your maximum was, make your best guess and mark "G" (for guess) next to your answer. In addition, please note any events related to your gaining weight during this period.

Age	Max Weight	Events Related to Weight Gain
5-10		
11-15		
16-20		
21-25		
26-30		
31-35		
36-40		
41-50		
51-60		
60-70		

SECTION D: WEIGHT, PREGNANCY, AND MENSTRUAL CYCLE
(For Women Only)

1. Have you borne children? Yes ☐ No ☐
   If yes:
   a. What was your weight at the start of your first pregnancy? lbs
      What was your weight at delivery? lbs
      What was your lowest weight after delivery? lbs

   b. What was your weight at the start of your second pregnancy? lbs
      What was your weight at delivery? lbs
      What was your lowest weight after delivery? lbs

   c. What was your weight at the start of your third pregnancy? lbs
      What was your weight at delivery? lbs
      What was your lowest weight after delivery? lbs

   d. What was your weight at the start of your fourth pregnancy? lbs
      What was your weight at delivery? lbs

What was your lowest weight after delivery? lbs

Please turn to the last page if you need more space.

2. Do you experience a regular menstrual cycle? Yes ☐ No ☐
   If yes:
   a. Describe your eating around the time of your menstruation. (Check one.)
      Eat much less ☐ Eat less ☐ No Change ☐ Eat More ☐ Eat Much More ☐

   b. Do you crave particular foods around the time of your menstruation? Yes ☐ No ☐

   c. If yes, which foods do you crave?

SECTION E: WEIGHT LOSS HISTORY

1. Please record any major weight loss efforts (i.e., diet, exercise, moderation, etc.) that resulted in a weight loss of 10 pounds or more. Think about your previous efforts, starting with the first one, whether in childhood or adulthood. You may have difficulty remembering this information at first, but most people can if they take their time. Start with your first weight loss effort and proceed in order until you reach your most recent one.

Age at time of effort	Weight at start of effort	#lbs lost	Method used to lose weight

Please turn to the last page if you need more space.

2. In the past year, how many times have you started a weight loss program on your own that lasted for more than 3 days?

3. In the past year, how many times have you started a weight loss program on your own that lasted for 3 days or less?

4. Have you ever experienced any significant physical or emotional symptoms while attempting to lose weight or after losing weight? Yes ☐ No ☐
   If you answered "yes," please describe your symptoms, including when they began, how long they lasted, and the type of help you sought, if any.

SECTION F: WEIGHT LOSS GOALS

1. How much would you like to lose at this time? lbs.

2. This would bring you down to a body weight of: lbs

3. When did you last weigh this amount?

4. How long was this weight maintained? months

5. Was it achieved after a weight loss effort? Yes ☐ No ☐

6. If you are successful in our program in changing your eating and exercising habits, how much
   weight do you realistically expect to lose after:
   6 months lbs. 12 months lbs. 24 months lbs.

SECTION G: SUBSTANCE USE

1. Do you smoke cigarettes? Yes ☐ No ☐
   If yes:
   a. How many do you smoke a day?
   b. How many years have you smoked?

2. Have you ever smoked cigarettes and stopped? Yes ☐ No ☐
   If yes:
   a. When did you stop smoking?
   b. How many cigarettes did you smoke in a day? /day
   c. Did you experience weight gain after quitting? Yes ☐ No ☐
      If yes, how many pounds?

3. During the past year
   a. How many glasses of wine did you typically drink a week?
   b. How many bottles of beer did you typically drink a week?
   c. How many mixed drinks or liqueurs did you typically have a week?

4. Have you ever had a problem with (or received treatment for) alcohol consumption or the use of other drugs?

Yes ☐ No ☐ If yes, please explain:

SECTION H: EATING HABITS

1. Please indicate the degree to which you believe each of the following behaviors causes you to gain weight. In answering these questions, please use the 5-point scale below. Pick the one number that best describes how much the behavior contributes to your increased weight.

1. Does not contribute at all
2. Contributes a small amount
3. Contributes a moderate amount
4. Contributes a large amount
5. Contributes the greatest amount

___A. Eating too much food
___B. Overeating at breakfast
___C. Overeating at lunch
___D. Overeating at dinner
___E. Snacking between meals
___F. Snacking after dinner
___G. Eating because I feel physically hungry
___H. Eating because I crave certain foods
___I. Continuing to eat because I don't feel full
___J. Eating because I can't stop once I've begun
___K. Eating because of the good taste of foods
___L. Eating in response to sight or smell of food
___M. Eating while cooking or preparing food
___N. Eating when anxious
___O. Eating when tired
___P. Eating when bored
___Q. Eating when stressed
___R. Eating when angry
___S. Eating when depressed/upset
___T. Eating when socializing/celebrating
___U. Eating when happy after a meal
___V. Eating when alone
___W. Eating with family/friends
___X. Eating at business functions

Please indicate any other factors that contribute a moderate or amount to your weight gain.

2. How many days a week do you eat the following meals? Write the number of days in the space and the usual time of each meal.

a. Breakfast: days a week Time: Morning Snack: days a week Time:
b. Lunch: days a week Time: Afternoon Snack: days a week Time:
c. Dinner: days a week Time: Evening Snack: days a week Time:

3. Who prepares meals at your home?
4. Who does the food shopping?
5. Please list your five favorite foods:

SECTION I: EATING PATTERNS I

The following questions on eating patterns are adapted from the Questionnaire on Eating and Weight Patterns – Revised by Yanovski, S.Z. (1993). Obesity Research, 1, 306-324.

1. During the past 6 months, did you often eat an unusually large amount of food within a two hour period (an amount that most people would agree is unusually large)? Yes ☐ No ☐

2. During the times when you ate an unusually large amount of food, did you often feel you could not stop eating or control what or how much you were eating? Yes ☐ No ☐

IF NO, SKIP TO QUESTION 11 in this section. DO NOT complete questions 3-10.

3. During the past 6 months, how often, on average, if at all, did you eat unusually large amounts of food? (There may have been some weeks when it was not present - just average those in.)
   - ☐ a. Less than one day a week
   - ☐ b. One day a week
   - ☐ c. Two or three days a week
   - ☐ d. Four or five days a week
   - ☐ e. Nearly every day

4. Did you usually have any of the following experiences during these occasions? Complete all items.
   a. Eating much more rapidly than usual? Yes ☐ No ☐
   b. Eating until you felt uncomfortably full? Yes ☐ No ☐
   c. Eating large amounts of food when you didn't feel physically hungry? Yes ☐ No ☐
   d. Eating alone because you were embarrassed by how much you were eating? Yes ☐ No ☐
   e. Feeling disgusted with yourself, depressed, or feeling very guilty after overeating? Yes ☐ No ☐
   f. Eating within 2.5 hours of having eaten another meal? Yes ☐ No ☐

5. Think about a typical time when you ate this way (that is, large amounts of food and feeling that your eating was out of control).
   What time of day did the episode start?
   - ☐ a. Morning (8am to 12 noon)
   - ☐ b. Early afternoon (12 noon to 4 pm)
   - ☐ c. Late afternoon (4pm to 7pm)
   - ☐ d. Evening (7pm to 10 pm)

☐ e. Night (after 10pm)

6. Approximately how long did this episode of eating last, from the time you started to eat until when you stopped and did not eat again for at least two hours? hours minutes

7. As best as you can remember, please list everything you may have eaten or drunk during that episode. Estimate as best as you can.

8. At the time this episode started, how long had it been since you had previously finished eating a meal or snack? hours minutes

9. In general during the past 6 months, how upset were you by overeating episodes in which you ate unusually large amounts of food? ☐ Not at all ☐ Slightly ☐ Moderately ☐ Greatly ☐ Extremely

10. In general during the past 6 months, how upset were you by feeling that you could not stop eating or could not control what or how you were eating?
☐ Not at all ☐ Slightly ☐ Moderately ☐ Greatly ☐ Extremely

11. In general during the past 6 months, how important has your weight or shape been in how you feel about or evaluate yourself as a person-compared to other aspects of your life (ie. how you do at work, as a parent, or how you get along with other people)? Weight and Shape …
☐ A. were not very important ☐ B. played a part in how I felt about myself
☐ C. were among the main things that affected how I felt about myself ☐ D. were the most important things that affected how I felt about myself

12. During the past 3 months, did you ever make yourself vomit in order to avoid gaining weight after binge eating? Yes ☐ No ☐

13. During the past 3 months, did you ever take more than twice the recommended dose of laxatives 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 ☐ Two or three times a week ☐ Four or five times a week
☐ More than five times a week.

14. During the past 3 months, did you ever take more than twice the recommended dose of diuretics (water pills) 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 ☐ Two or three times a week ☐ Four or five times a week ☐ More than five times a week.

15. During the past 3 months, did you ever fast (not eat anything at all for at least 24 hours) 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 ☐ Two or three times a week ☐ Four or five times a week ☐ More than five times a week.

16. During the past 3 months, did you ever exercise for more than one hour specifically in order to avoid gaining weight after eating? Yes ☐ No ☐
    If yes, How often on average was that?
    ☐ Less than once a week ☐ Once a week ☐ Two or three times a week ☐ Four or five times a week ☐ More than five times a week.

17. During the past 3 months, did you ever take more than twice the recommended dosage 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 ☐ Two or three times a week ☐ Four or five times a week ☐ More than five times a week.

SECTION K: EATING PATTERNS II

Directions: Please choose ONE answer for each question.

1. How hungry are you usually in the morning?
   ☐ 0: Not at all ☐ 1: A little ☐ 2: Somewhat ☐ 3: Moderately ☐ 4: Very

2. When do you usually eat for the first time?
   ☐ 0: Before 9 am ☐ 1: 9:01-12 am ☐ 2: 12:01-3 pm ☐ 3: 3:01-6 pm ☐ 4: 6:01 pm or later

3. Do you have cravings or urges to eat snacks after supper, but before bedtime?
   ☐ 0: Not at all ☐ 1: A little ☐ 2: Somewhat ☐ 3: Moderately ☐ 4: Very

4. How much control do you have over your eating between supper and bedtime?
   ☐ 0: Not at all ☐ 1: A little ☐ 2: Somewhat ☐ 3: Moderately ☐ 4: Very

5. How much of your daily food intake do you consume *after* suppertime?
   ☐ 0%- None ☐ 26-50%- about half ☐ 51-75%- more than half ☐ 76-100% - almost all

6. Are you currently feeling blue or down in the dumps?
   ☐ 0: Not at all ☐ 1: A little ☐ 2: Somewhat ☐ 3: Moderately ☐ 4: Very

7. When you are feeling blue, is your mood lower in the:
   ☐ 0: Early Morning ☐ 1: Late Morning ☐ 2: Afternoon ☐ 3: Early Evening ☐ 4: Late Evening/Night ☐ 5: My mood does not change during the day.

8. How often do you have trouble getting to sleep?
   ☐ 0: Never ☐ 1: Sometimes ☐ 2: About half of the time ☐ 3: Usually ☐ 4: Always

9. Other than only to use the bathroom, how often do you get up at least once in the middle of the night?
   ☐ 0: Never ☐ 1: Less than once a week ☐ 2: About once a week ☐ 3: More than once a week ☐ 4: Every night

   *****If 0 on #9, Please Skip to Section L: Physical Activity******

10. Do you have cravings or urges to eat snacks when you wake up at night?
    ☐ 0: Not at all ☐ 1: A little ☐ 2: Somewhat ☐ 3: Moderately ☐ 4: Very

11. Do you need to eat in order to get back to sleep when you awake at night?
    ☐ 0: Not at all ☐ 1: A little ☐ 2: Somewhat ☐ 3: Moderately ☐ 4: Very

12. When you get up in the middle of the night, how often do you snack?
    ☐ 0: Not at all ☐ 1: A little ☐ 2: Somewhat ☐ 3: Moderately ☐ 4: Very

13. When you snack in the middle of the night, how aware are you of your eating?
    ☐ 0: Not at all ☐ 1: A little ☐ 2: Somewhat ☐ 3: Moderately ☐ 4: Very

14. How much control do you have over your eating while you are up at night?
    ☐ 0: Not at all ☐ 1: A little ☐ 2: Somewhat ☐ 3: Moderately ☐ 4: Very

15. How long have your difficulties with night eating been going on? months
    years

The Night Eating Questionnaire is reprinted here from:
Allison KC, Stunkard AJ, Their SL. Overcoming Night Eating Syndrome: A step-by-step guide to breaking the cycle. Oakland, CA: New Harbinger, 2004

SECTION L: PHYSICAL ACTIVITY

1. To what extent do you enjoy physical activity?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Greatly

2. Do you have any physical problems that limit your physical activity? Yes ☐ No ☐
   a. If yes, please describe.

3. Please check the types of physical activity you enjoy. Check only those that you have participated in *during the last year*.

☐ a. walking outside
☐ b. walking indoors
☐ c. jogging
☐ d. running
☐ j. basketball
☐ n. other, please describe
☐ f. biking (stationary)
☐ g. aerobic class
☐ h. tennis/racket sports
☐ i. swimming
☐ k. golf
☐ l. dancing
☐ m. strength training
☐ e. biking outside

4. For your most preferred activity, how many times have you participated in this activity in the past 6 months? times

5. How many hours of TV do you watch on an average weekday? hours

6. How many hours of TV do you watch on an average weekend day? hours

7. Approximately how many city blocks or the equivalent do you regularly walk each day? blocks (12 blocks = 1 mile)

8. How many flights of stairs do you climb up each day? flights a day (1 flight = 10 steps)

9. Please describe your daily lifestyle activity (i.e. how active you are) by picking any number from 1 to 10 in which 1 = very sedentary and 10 = very active. Your number is:

SECTION M: FAMILY AND LIVING ARRANGEMENTS

1. I am currently: (check one)
   ☐ Single
   ☐ Married
   ☐ Divorced
   ☐ Separated
   ☐ Widowed

2. Currently, I am: (check all that apply)
   ☐ living alone
   ☐ living with a spouse/partner
   ☐ living with a significant other
   ☐ living with children
   ☐ living with parents/step-parents
   ☐ living with other relatives
   ☐ living with roommates

3. Please indicate the total number of persons living in your home.

4. If you are currently involved in an intimate relationship (significant other), please answer these questions.

   What is this person's attitude towards your efforts to lose weight?
   ☐ Strongly Supports my efforts ☐ Supports my efforts ☐ Neutral ☐ Opposes my Efforts ☐ Strongly Opposes my efforts

   Please describe briefly what this person does either to help or hinder your efforts to lose weight.

5. How satisfied are you with your overall relationship with this person?

6. Will other people support your efforts to lose weight? Yes ☐ No ☐
   If yes, how many people will: Who are those people?
   How many of these people are helpful to you?
7. How many people do you talk with about your weight when you are upset about it?

   How many of these people are helpful to you?

8. Will other people oppose or undermine your efforts to lose weight? Yes ☐ No ☐
   If yes, how many will?
   Who are these people?

SECTION N: SELF- PERCEPTIONS

1. How satisfied are you with your current weight?
   ☐ Very Satisfied ☐ Moderately Satisfied ☐ Slightly Satisfied ☐ Neutral ☐ Slightly Unsatisfied ☐ Moderately Unsatisfied ☐ Very Unsatisfied

2. How satisfied are you with your current shape (i.e., figure or physique)?
   ☐ Very Satisfied ☐ Moderately Satisfied ☐ Slightly Satisfied ☐ Neutral ☐ Slightly Unsatisfied ☐ Moderately Unsatisfied ☐ Very Unsatisfied

3. How satisfied are you with your current overall appearance?
   ☐ Very Satisfied ☐ Moderately Satisfied ☐ Slightly Satisfied ☐ Neutral ☐ Slightly Unsatisfied ☐ Moderately Unsatisfied ☐ Very Unsatisfied

4. Pick the one sentence that best describes your overall feelings about yourself. "In general, I am …"

☐ Very happy with who I am ☐ Happy with who I am ☐ Ok but have some mixed feelings ☐ Unhappy with who I am ☐ Very unhappy with who I am

5. "As compared with most people, I think I have…"
   ☐ Very happy with who I am ☐ Happy with who I am ☐ Ok but have some mixed feelings ☐ Unhappy with who I am ☐ Very unhappy with who I am

6. Pick the one sentence that best describes your feelings about the way you looked the last time you lost a lot of weight. "I was…"
   ☐ Very happy with the way I looked ☐ Happy with the way I looked ☐ Ok but have some mixed feelings ☐ Unhappy with the way I looked ☐ Very unhappy with the way I looked

7. How much weight did you lose? lbs
   At what weight did you start to diet during this time? lbs

SECTION O: PSYCHOLOGICAL FACTORS

1. Have you ever had any problems at any time with depression, anxiety, or other emotions that disrupted your normal functioning? Yes ☐ No ☐

2. Have you ever sought professional help for emotional problems? Yes ☐ No ☐
   If yes, specify below.

Problem	**Year**	**Duration (wks)**	**Type of Professional Help**

3. During the past month, have you felt depressed, sad, or blue much of the time? Yes ☐ No ☐

4. During the past month, have you often felt hopeless about the future? Yes ☐ No ☐

5. During the past month, have you had little interest or pleasure in doing things? Yes ☐ No ☐

6. Have you ever been subjected to physical abuse? Yes ☐ No ☐

7. Have you ever been subjected to sexual abuse? Yes ☐ No ☐

8. Are any of your immediate family members alcoholic? Yes ☐ No ☐

SECTION P: TIMING

1. Please indicate if you are currently experiencing any <u>greater than usual stress</u> in your life related to the following events.

a. Work	Yes ☐ No ☐
b. Health	Yes ☐ No ☐
c. Relationship with spouse/significant others	Yes ☐ No ☐
d. Activities related to your children	Yes ☐ No ☐
e. Activities related to your parents	Yes ☐ No ☐
f. Legal/financial trouble	Yes ☐ No ☐
g. School	Yes ☐ No ☐
h. Moving	Yes ☐ No ☐

i. Other
Please explain in a sentence any items to which you responded yes:

2. Are you planning any major life changes (i.e., new job, moving, relationship, etc.) during the next 6 months? Yes ☐ No ☐
If yes, please briefly describe below

3. How stressful has your life been <u>during the past 6 months</u>?
☐ Much less stressful than usual ☐ Less Stressful than usual ☐ Average level of stress ☐ More stressful than usual ☐ Much more stressful than usual

4. How stressful do you think that your life will be <u>in the next 6 months</u>, excluding your efforts to lose weight?
☐ Much less stressful than usual ☐ Less Stressful than usual ☐ Average level of stress ☐ More stressful than usual ☐ Much more stressful than usual

5. How motivated are you to lose weight at this time? Pick a number between 1 and 10, in which 1 = not motivated and 10 = greatest motivation you have ever had. Your number is

6. Why do you want to lose weight right now, as compared to 1 year ago? What has prompted you to lose weight now?

7. What is the single most important thing that you hope to achieve as a result of losing weight?

8. People who want to achieve long-term weight control need to spend at least 30 minutes a day, for a minimum of 6 months trying to change their eating, exercise, and thinking habits. Please check the number below that best describes you:

   ☐ 1. I definitely will not be able to devote 30 minutes daily to weight control
   ☐ 2. I'm not sure if I can find 30 minutes daily for weight control
   ☐ 3. I can definitely find 30 minutes daily for weight control
   ☐ 4. I can devote more than 30 minutes daily to weight control

9. Rate how confident you are that you will be able to significantly change your eating and exercise habits. Pick a number from 1 to 10 in which 1 = not at all confident and 10 = extremely confident. Your number is

SECTION Q: MEDICAL HISTORY

1. Please indicate if you have had any of the medical conditions listed below:

Heart Disease	Yes ☐ No ☐
Angina	Yes ☐ No ☐
Palpitations, heart beats fast or hard	Yes ☐ No ☐
Stroke, mild stroke (cerebrovascular accident)	Yes ☐ No ☐
Rheumatic fever	Yes ☐ No ☐
Heart murmur	Yes ☐ No ☐
Pacemaker	Yes ☐ No ☐
Breathing problems (asthma, lung disease)	Yes ☐ No ☐
High blood pressure	Yes ☐ No ☐
Anemia	Yes ☐ No ☐
Back problems	Yes ☐ No ☐
Joint or bone problems	Yes ☐ No ☐
Hiatal hernia	Yes ☐ No ☐
Arthritis	Yes ☐ No ☐
Gout (elevated uric acid)	Yes ☐ No ☐
Gallbadder disease	Yes ☐ No ☐
Thyroid problems	Yes ☐ No ☐
Kidney disease	Yes ☐ No ☐
Ulcers	Yes ☐ No ☐
Bowel disease	Yes ☐ No ☐
Liver disease	Yes ☐ No ☐
Diabetes (type I or II)	Yes ☐ No ☐

Sleep Apnea Yes ☐ No ☐

Bodily pain Yes ☐ No ☐

Other (specify)

2. List all medications you currently take (including vitamins & supplements).

Medication	Dosage	Frequency	Reason for taking

Please indicate your primary care physician's name, telephone number, and address here:

Name: Phone:

Address:

ADDITIONAL INFORMATION – please use this space to provide any additional information that you think is important to understand you or your weight problem, as well as the goals you seek.