

SCREENING QUESTIONNAIRE

Name :

Date:

For each question choose from the following alternatives:

0 Never 1 Almost Never 2 Sometimes 3 Fairly Often 4 Very Often

| | | | | | | |
|---|---|---|---|--------|----------------------|--------------------------|
| 1. In the last month, how often have you been upset because of something that happened unexpectedly? | 0 | 1 | 2 | 3 | 4 | <input type="checkbox"/> |
| 2. In the last month, how often have you felt that you were unable to control the important things in your life? | 0 | 1 | 2 | 3 | 4 | <input type="checkbox"/> |
| 3. In the last month, how often have you felt nervous and stressed? | 0 | 1 | 2 | 3 | 4 | <input type="checkbox"/> |
| 4. In the last month, how often have you felt confident in your ability to handle your personal problems? | 0 | 1 | 2 | 3 | 4 | <input type="checkbox"/> |
| 5. In the last month, how often have you felt that things were going your way? | 0 | 1 | 2 | 3 | 4 | <input type="checkbox"/> |
| 6. In the last month, how often have you found that you could not cope with all the things that you had to do? | 0 | 1 | 2 | 3 | 4 | <input type="checkbox"/> |
| 7. In the last month, how often have you been able to control irritations in your life? | 0 | 1 | 2 | 3 | 4 | <input type="checkbox"/> |
| 8. In the last month, how often you felt that you were on top of things? | 0 | 1 | 2 | 3 | 4 | <input type="checkbox"/> |
| 9. In the last month, how often have you been angered because of things that happened that were outside your control? | 0 | 1 | 2 | 3 | 4 | <input type="checkbox"/> |
| 10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them? | 0 | 1 | 2 | 3 | 4 | <input type="checkbox"/> |
| | | | | Total: | <input type="text"/> | <input type="text"/> |

| Over the <u>last 2 weeks</u> , how often have you been bothered by any of the following problems? <i>(circle to indicate your answer)</i> | Not at all | Several days | More than half the days | Nearly every day |
|---|------------|--------------|-------------------------|------------------|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 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 | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all/Somewhat Difficult/ Very Difficult/ Extremely Difficult

| Over the last 2 weeks, how often have you been bothered by the following problems? <i>(circle to indicate your answer)</i> | Not at all | Several days | More than half the days | Nearly every day |
|---|------------|--------------|-------------------------|------------------|
| 1. Feeling nervous, anxious or on edge | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 3. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 4. Trouble relaxing | 0 | 1 | 2 | 3 |
| 5. Being so restless that it is hard to sit still | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 7. Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all/Somewhat Difficult/ Very Difficult/ Extremely Difficult

| Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment. | Never | Rarely | Sometimes | Often | Very Often |
|---|-------|--------|-----------|-------|------------|
| 1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done? | | | | | |
| 2. How often do you have difficulty getting things in order when you have to do a task that requires organization? | | | | | |
| 3. How often do you have problems remembering appointments or obligations? | | | | | |
| 4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started? | | | | | |
| 5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time? | | | | | |
| 6. How often do you feel overly active and compelled to do things, like you were driven by a motor? | | | | | |
| Part A | | | | | |
| 7. How often do you make careless mistakes when you have to work on a boring or difficult project? | | | | | |
| 8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work? | | | | | |
| 9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly? | | | | | |
| 10. How often do you misplace or have difficulty finding things at home or at work? | | | | | |
| 11. How often are you distracted by activity or noise around you? | | | | | |
| 12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated? | | | | | |
| 13. How often do you feel restless or fidgety? | | | | | |
| 14. How often do you have difficulty unwinding and relaxing when you have time to yourself? | | | | | |
| 15. How often do you find yourself talking too much when you are in social situations? | | | | | |
| 16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves? | | | | | |
| 17. How often do you have difficulty waiting your turn in situations when turn taking is required? | | | | | |
| 18. How often do you interrupt others when they are busy? | | | | | |
| Part B | | | | | |

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't 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 = Slight chance of dozing
- 2 = Moderate chance of dozing
- 3 = High chance of dozing

| Situation | Chance of dozing |
|---|-------------------------|
| Sitting and reading | <input type="text"/> |
| Watching TV | <input type="text"/> |
| Sitting, inactive in a public place (e.g. a theatre or a meeting) | <input type="text"/> |
| As a passenger in a car for an hour without a break | <input type="text"/> |
| Lying down to rest in the afternoon when circumstances permit | <input type="text"/> |
| Sitting and talking to someone | <input type="text"/> |
| Sitting quietly after a lunch without alcohol | <input type="text"/> |
| In a car, while stopped for a few minutes in the traffic | <input type="text"/> |
| Total | <input type="text"/> |

Snoring?

- Yes No
 Do you **Snore Loudly** (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?

Tired?

- Yes No
 Do you often feel **Tired, Fatigued, or Sleepy** during the daytime (such as falling asleep during driving or talking to someone)?

Observed?

- Yes No
 Has anyone **Observed** you **Stop Breathing** or **Choking/Gasping** during your sleep?

Pressure?

- Yes No
 Do you have or are being treated for **High Blood Pressure**?

Tick **Yes** or **No** for each statement as it applies to you

Yes No You eat, in any 2 hours, an amount of food that is definitely larger than most people would eat over a similar period of time in a similar situation

Yes No You feel a loss of control over eating during these episodes. For example, you feel like you cannot stop eating or control what and how much you are eating

During these episodes:

Yes No You eat faster than normal

Yes No You eat until you feel uncomfortably full

Yes No You eat a large amount of food when you do not feel physically hungry

Yes No You eat alone because you are embarrassed by how much you are eating

Yes No You feel disgusted with yourself, depressed, or very guilty after overeating

Yes No You feel very worried or upset if/when you eat like this

Yes No On average these episodes occur on 1 or more days a week and have been going on for 3 consecutive months or longer

Yes No Your excessive eating is followed by actions like purging (vomiting, laxative use), fasting (not eating at all), and/or excessive exercise

Yes No You have seen a doctor for an eating disorder like anorexia or bulimia

Please read every question and indicate (circle) how much you agree or disagree

0 Strongly Disagree 1 Disagree 2 Neither Agree or Disagree 3 Agree 4 Strongly Agree

| | | | | | |
|--|---|---|---|---|---|
| 1. I feel out of control in the presence of delicious food. | 0 | 1 | 2 | 3 | 4 |
| 2. When I start eating, I just can't seem to stop. | 0 | 1 | 2 | 3 | 4 |
| 3. It is difficult for me to leave food on my plate. | 0 | 1 | 2 | 3 | 4 |
| 4. When it comes to foods I love, I have no willpower. | 0 | 1 | 2 | 3 | 4 |
| 5. I get so hungry that my stomach often seems like a bottomless pit. | 0 | 1 | 2 | 3 | 4 |
| 6. I don't get full easily. | 0 | 1 | 2 | 3 | 4 |
| 7. It seems like most of my waking hours are preoccupied by thoughts about eating or not eating. | 0 | 1 | 2 | 3 | 4 |
| 8. I have days when I can't seem to think about anything else but food. | 0 | 1 | 2 | 3 | 4 |
| 9. Food is always on my mind. | 0 | 1 | 2 | 3 | 4 |
| 10. I feel hungry all the time. | 0 | 1 | 2 | 3 | 4 |
| 11. I can't stop thinking about eating no matter how hard I try. | 0 | 1 | 2 | 3 | 4 |
| 12. I find myself continuing to consume certain foods even though I am no longer hungry. | 0 | 1 | 2 | 3 | 4 |
| 13. If food tastes good to me, I eat more than usual. | 0 | 1 | 2 | 3 | 4 |

Based on the previous 7 days, patients were asked to rate the following questions on a 10 cm visual analogue scale (VAS):

| | |
|---------|---|
| COEQ_1 | How often have you had food cravings? (never/very often). |
| COEQ_2 | How strong have any food cravings been on average? (not at all strong/extremely strong). |
| COEQ_3 | Overall, how difficult has it been to control your eating? (not at all difficult/extremely difficult). |
| COEQ_4 | How difficult has it been to resist any food cravings? (not at all difficult/extremely difficult). |
| COEQ_5 | How often have you eaten in response to food cravings? (never/after every food craving). |
| COEQ_6 | How difficult has it been to control your meal portion sizes? (not at all difficult/extremely difficult). |
| COEQ_7 | How hungry have you felt? (not at all hungry/extremely hungry). |
| COEQ_8 | How full have you felt after meals? (not at all full/as full as I have ever felt). |
| COEQ_9 | How often have you had thoughts of food? (rarely/very often). |
| COEQ_10 | How pleasant have your meals been? (not at all pleasant/extremely pleasant). |
| COEQ_11 | How often have you had food cravings for chocolate or chocolate flavoured foods? (never/very often) |
| COEQ_12 | How often have you had food cravings for other sweet foods? (never/very often). |
| COEQ_13 | How often have you had food cravings for fruit or fruit juice? (never/very often). |
| COEQ_14 | How often have you had food cravings for savoury foods? (never/very often). |

The following questions ask about your eating patterns and behaviors within the last 3 months. For each question, choose the answer that best applies to you.

| | | |
|--|-----|----|
| 1. During the last 3 months, did you have any episodes of excessive overeating (i.e., eating significantly more than what most people would eat in a similar period of time)? | Yes | No |
|--|-----|----|

NOTE: IF YOU ANSWERED "NO" TO QUESTION 1, YOU MAY STOP. THE REMAINING QUESTIONS DO NOT APPLY TO YOU.

| | | |
|---|-----|----|
| 2. Do you feel distressed about your episodes of excessive overeating? | Yes | No |
|---|-----|----|

| Within the past 3 months... | Never or Rarely | Sometimes | Often | Always |
|--|-----------------|-----------|-------|--------|
| 3. During your episodes of excessive overeating, how often did you feel like you had no control over your eating (e.g., not being able to stop eating, feel compelled to eat, or going back and forth for more food)? | | | | |
| 4. During your episodes of excessive overeating, how often did you continue eating even though you were not hungry? | | | | |
| 5. During your episodes of excessive overeating, how often were you embarrassed by how much you ate? | | | | |
| 6. During your episodes of excessive overeating, how often did you feel disgusted with yourself or guilty afterward? | | | | |
| 7. During the last 3 months, how often did you make yourself vomit as a means to control your weight or shape? | | | | |