MOVE! 23 (*MOVE!* Questionnaire)

Paper and pencil version

Please print.

VA FACILITY:_____

NAME:_____

DATE:_____

SSN: ____-____-____ (Please give all nine digits.)

Height:_____(feet)_____ (inches)

Weight:_____(lbs)

(Please enter measured height and today's weight – Your Body Mass Index or BMI will be calculated from this measurement. Height should be measured without shoes.)

Date of Birth: Month____ /Day____ /Year____

Male or Female (Circle one.)

Ethnicity

Do you consider yourself to be Hispanic or Latino? Select one.

- □ Hispanic or Latino
  A person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race
- □ Not Hispanic or Latino
- □ I do not wish to provide this information.

Race

What race do you consider yourself to be? Select one or more of the following.

- □ American Indian or Alaskan Native
  A person having origins in any of the original peoples of North, Central or South America, and who maintains tribal affiliation or community attachment

- □ Asian
  A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam

- □ Black or African American
  A person having origins in any of the black racial groups of Africa

- □ Native Hawaiian or Other Pacific Islander
  A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands

- □ White
  A person having origins in any of the original peoples of Europe, the Middle East, or North Africa

- □ I do not wish to provide this information.

Check the appropriate option(s) below.

Are you completing this questionnaire (*MOVE!23*)…

- □ as a veteran?
- □ for yourself as an employee?

Please complete the following questionnaire.
(All information is confidential and subject to applicable laws regarding privacy of patient records.)

1. I consider myself to be (check one):

   a. _____ Underweight for my height and age
   b. _____ Normal weight for my height and age
   c. _____ Overweight for my height and age

2. In general, would you say that your health is (check one):
   a. _____ Excellent
   b. _____ Very Good
   c. _____ Good
   d. _____ Fair
   e. _____ Poor

3. Please indicate (with a check mark to the left) any of the following that apply to you:

   _____ Shortness of breath at rest
   _____ Chest pains not previously evaluated by your physician
   _____ Active infection of any kind
   _____ Hernia in the groin or belly area
   _____ Retinal hemorrhage (bleeding in the back of the eye)
   _____ Loss of balance because of dizziness or passing out
   _____ Any chronic medical problem that has recently been out-of-control, unstable or flared up
   _____ Arthritis or joint pain
   _____ Back pain or spinal disc disease
   _____ Osteoporosis or bone disease
   _____ Amputation
   _____ Spinal cord injury
   _____ Lung disease such as emphysema, COPD, or asthma
   _____ Heart disease such as heart failure, heart attack or angina, heart surgery or angioplasty, irregular heartbeat, implanted defibrillator or pacemaker, heart valve problems
   _____ Poor blood circulation in the legs
   _____ Stroke or TIAs (mini-strokes) or carotid artery surgery in the neck
   _____ Diabetes – even if controlled by medication or diet
   _____ High blood pressure - even if controlled by medication or diet
   _____ High blood cholesterol - even if controlled by medication or diet
   _____ Someone in your immediate family with heart problems at an age younger than 50
   _____ None of the above

Please indicate any of the following that apply to you:

_____ Too much stress
_____ General unhappiness
_____ Depression
_____ Anxiety problems or nervousness
_____ Family or relationship problems
_____ Bipolar disorder (Manic depressive disorder)
_____ Schizophrenia
_____ Post traumatic stress disorder (PTSD)
_____ Obsessive/compulsive disorder
_____ Eating disorder/binge eating/anorexia/bulimia
_____ Tobacco Use/Smoking
_____ Substance Abuse or Dependence
_____ None of these

4. Have you tried to lose weight in the past? (Circle one.) Yes No

If so, what of the following options have you tried in order to lose weight? Check all that apply.

a. ____ Some form of dieting, that is eating differently from the way you usually eat for the sake of losing weight
b. ____ Avoiding particular foods or food groups
c. ____ Physical exercise, such as walking, swimming or calisthenics
d. ____ Prepackaged meals
e. ____ Meal replacements in bar, powder, liquid, tablet/pill or water form
f. ____ Fasting for 24 hours or longer
g. ____ Skipping meals
h. ____ Hypnosis
i. ____ Comprehensive weight loss program with dietary changes, physical activity, and behavioral counseling
j. ____ Any other kind of weight loss program that does **NOT** provide comprehensive treatment (dietary changes, physical activity, and behavioral counseling)
k. ____ Keeping a log or journal for eating or exercise
l. ____ Causing yourself to vomit after you eat
m. ____ Cosmetic procedure such as liposuction or other
n. ____ Weight loss medical procedure such as gastric bypass, gastric banding, wiring of your jaw or other
o. ____ Taking a prescription medication to lose weight
p. ____ Taking an over the counter (OTC) medication; vitamin, mineral, or nutrient supplement; herbal supplement; naturopathic or alternative medicine preparation or supplement to lose weight
q. ____ Smoking to control weight
r. ____ Other

5. Are you trying to lose weight now? (Circle one.) Yes No

If so, what does your current weight loss plan include? Check all that apply.

a. ____ Some form of dieting, that is eating differently from the way you usually eat for the sake of losing weight
b. ____ Avoiding particular foods or food groups
c. ____ Physical exercise, such as walking, swimming or calisthenics
d. ____ Prepackaged meals
e. ____ Meal replacements in bar, powder, liquid, tablet/pill or water form
f. ____ Fasting for 24 hours or longer
g. ____ Skipping meals
h. ____ Hypnosis
i. ____ Comprehensive weight loss program with dietary changes, physical activity, and behavioral counseling
j. ____ Any other kind of weight loss program that does **NOT** provide comprehensive treatment (dietary changes, physical activity, and behavioral counseling)
k. ____ Keeping a log or journal for eating or exercise
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m. ____ Cosmetic procedure such as liposuction or other
n. ____ Weight loss medical procedure such as gastric bypass, gastric banding, wiring of your jaw or other
o. ____ Taking a prescription medication to lose weight
p. ____ Taking an over the counter (OTC) medication; vitamin, mineral, or nutrient supplement; herbal supplement; naturopathic or alternative medicine preparation or supplement to lose weight
q. ____ Smoking to control weight
r. ____ Other

6. Select the answer that best describes your rate of weight gain over the years.

a. _____ I have been overweight since childhood (before age 18).
b. _____ I have gained weight gradually over the years.
c. _____ I have gained most of my excess weight in a short period of time.
d. _____ I have gained and lost weight many times over the years ("yo-yo").

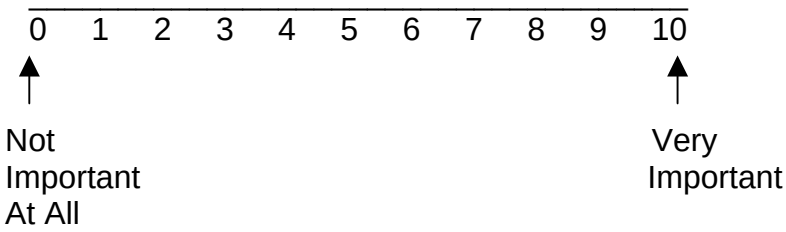
7. Select the answer that best describes your family:

a. _____ As a group, my family is not overweight or obese.
b. _____ As a group, some members of my family are overweight or obese.
c. _____ As a group, most members of my family are overweight or obese.

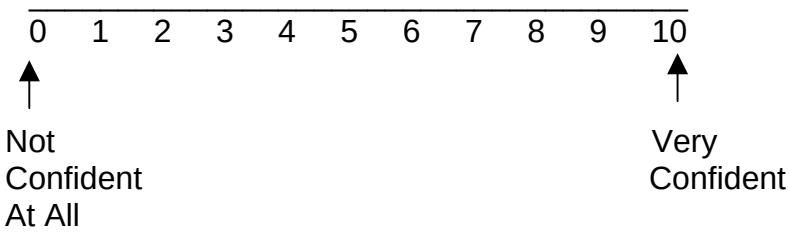
8. How much can you rely on family or friends for support and encouragement? (Check one.)

a. _____ A lot
b. _____ Somewhat
c. _____ Not at all

9. How important is controlling your weight to you personally? Please circle the number that applies. Please do not place a circle in the space between numbers.



10. How confident are you that you can successfully change your eating and physical activity to control your weight? Please circle the number that applies. Please do not place a circle in the space between numbers.



11. Check the statement that **most closely** applies to you:

a. _____ I am not considering trying to control my weight at this time.
b. _____ I am considering trying to control my weight sometime within the next six months**.**
c. _____ I am ready to make some changes to control my weight*.*
d. _____ I am actively working on controlling my weight at this time.
e. _____ I have been continuously and successfully doing things to control my weight for more than the last six months.

12. How much weight do you think you realistically **could lose** in one year? (Check one.)

a. _____ 10 lbs or less
b. _____ 11 – 25 lbs
c. _____ 26 – 50 lbs
d. _____ 51 - 100 lbs
e. _____ more than 100 lbs

13. How satisfied are you with the appearance of your body? (Check one.)

a. _____ Very satisfied
b. _____ Moderately satisfied
c. _____ Neither satisfied or dissatisfied
d. _____ Moderately dissatisfied
e. _____ Very dissatisfied

14. Do any of the following have anything to do with your being overweight?
Check all that apply to you.

a. _____ Eating because of emotions or stress
b. _____ Family or relationship problems
c. _____ Boredom
d. _____ Loneliness or Loss of loved one
e. _____ Eating too much
f. _____ Poor food choices or habits
g. _____ Not getting enough physical activity
h. _____ Difficulty with self control
i. _____ Hungry all the time
j. _____ Feeling bad about myself
k. _____ Love to eat
l. _____ Quitting tobacco use
m. _____ Pregnancy/Childbirth
n. _____ Illness or injury
o. _____ Medications led to weight gain
p. _____ Other
q. _____ None of the above

15. What do you think may get in the way of **changing** your **eating** habits? Check all that apply to you.

a. _____ Eating food from restaurants, fast food places, convenience stores, vending machines
b. _____ Person who prepares my food is uncooperative or unsupportive
c. _____ Too much high calorie food available at home or work
d. _____ Too little time to prepare and eat healthy food
e. _____ Too little money to buy healthy food
f. _____ Feeling hungry much of the time
g. _____ Used to eating a certain way
h. _____ Difficulties such as stress or depression
i. _____ Being with others who overeat
j. _____ Don't know how
k. _____ Other
l. _____ Nothing should get in the way

16. How many times a **day** do you typically eat, including snacks? (Check one.)

a. _____ 1 time a day
b. _____ 2 times a day
c. _____ 3 times a day
d. _____ 4 times a day
e. _____ 5 or more times each day

17. How many times per week do you eat at restaurants or buy 'take out' food?

Please indicate on the line below the number of times between 0 and 21. Consider breakfast, lunch and supper 7 days a week for a total of 21 meals for which restaurant or take out food could be eaten.

_____

When you eat out, do you find that you overeat or eat higher calorie foods?

a. _____ Yes
b. _____ No

18. How much juice (including juice-drinks) or sugar-sweetened soda, tea or other beverages do you drink **most days**? (Check one option below.)

a. _____ I don't drink juice; juice-drinks; or sugar-sweetened soda, tea or other beverages.
b. _____ 1 – 2 cups, cans, small bottles or drink boxes per day
c. _____ 3 or more cups, cans, small bottles or drink boxes per day

19. Do you drink alcoholic beverages (such as beer, malt liquor, wine, wine coolers, hard/distilled liquor)? (Check one.)

a. _____ Yes
b. _____ No

20. How **fast** do you usually eat? (Check one.)

a. _____ I eat slowly.
b. _____ I eat at a moderate pace.
c. _____ I eat fast.

21. On average, how often have you eaten extremely large amounts of food at one time and felt that your eating was out of control at that time? (Check one.)

a. _____ Never
b. _____ Less than 1 time per week
c. _____ 1 time per week
d. _____ 2 to 4 times a week
e. _____ 5 or more times a week

22. What do you think may get in the way of **changing** your **physical activity** habits? Check all that apply to you.

a. _____ Too little time
b. _____ Too little money
c. _____ Safety concerns
d. _____ No place to walk or be active
e. _____ No transportation
f. _____ Lack of support or encouragement from others
g. _____ Difficulties such as stress, depression, etc.
h. _____ Do not like to exercise
i. _____ Daily habits or routines that do not include exercise
j. _____ Pain
k. _____ Amputation
l. _____ Back problems
m. _____ Arthritis
n. _____ Muscular problems
o. _____ Heart or lung disease
p. _____ Joint problems
q. _____ Spinal cord injury
r. _____ Too tired
s. _____ Job or work schedule
t. _____ Other
u. _____ Nothing should get in the way

23. This next question asks about your physical activity habits. There are two types of activity to consider:

- Moderate physical activities cause light sweating and a slight to moderate increase in breathing or heart rate. Examples include brisk walking, bicycling, vacuuming, gardening, and golfing without a cart.

- Vigorous activities cause heavy sweating and large increases in breathing or heart rate. Examples include running, aerobic classes, heavy yard work, and briskly swimming laps.

a. How many days per week do you do moderate activities for at least 10 minutes at a time? Please circle the appropriate number. Please do not place a circle in the space between numbers.

0 1 2 3 4 5 6 7

b. On days when you do moderate activities for at least 10 minutes at a time, how much total time per day do you spend doing these activities? (Select one choice below.)

a. _____ 10-19 minutes
b. _____ 20-29 minutes
c. _____ 30-59 minutes
d. _____ >=60 minutes

c. How many days per week do you do vigorous activities for at least 10 minutes at a time? Please circle the appropriate number. Please do not place a circle in the space between numbers.

0 1 2 3 4 5 6 7

d. On days when you do vigorous activities for at least 10 minutes at a time, how much total time per day do you spend doing these activities? (Select one choice below.)

a. _____ 10-19 minutes
b. _____ 20-29 minutes
c. _____ 30-59 minutes
d. _____ >=60 minutes