

TRIALS OF HYPERTENSION PREVENTION  
 PARTICIPANT EVALUATION--Combined

We are very interested in learning what lifestyle changes you may have made during TOHP. Your answers to the following questions will help us in knowing this information and will be kept strictly confidential.

1. How difficult was it to find foods that were lower in Sodium **and** fat calories?
 

Very Difficult                       Somewhat Difficult                       Easy
  
2. Since joining TOHP, have you started eating **low sodium and low fat calories** versions of any of the following food groups? (Mark all that apply.)
  - Dairy (milk, cream, cheese, yogurt)
  - Red Meat (Beef, pork, lamb, veal, organ meats)
  - Poultry (chicken, turkey, game)
  - Fish (fish, seafood, shellfish)
  - Eggs
  - Soup
  - Legumes (peas, beans, nuts, seeds)
  - Grains (flour, cereals, breads, desserts)
  - Fruits (fruits, juices, berries)
  - Vegetables
  - Fats/Oils (butter, margarine, salad dressings, sauces)
  - Sweets/Beverages (coffee, tea, nonalcoholic beverages, soda, sugars)
  - Alcoholic Beverages (beer, wine, liquor, mixed drinks)
  - None of the above
  
3. Food labeling has changed since TOHP started. Has this made following your TOHP weight program:
 

Easier                       Harder                       No difference
  
4. On average, how successful do you think you were in meeting your TOHP weight program goals?
 

Very Successful	Successful	No Opinion	Not Very Successful	Not at All Successful
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
  
5. In your efforts to meet your TOHP weight and sodium goals how useful were the following components of TOHP?
 

	Very Useful	Moderately Useful	Not Useful	Did not have/ Do not recall
a. weekly clinic weigh-in	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. sharing with group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. weekly goals and action plans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- |   | Very Useful              | Moderately Useful        | Not Useful               | Did not have/<br>Do not recall |
|---|--------------------------|--------------------------|--------------------------|--------------------------------|
| d. behavioral topics (cues, rewards, self-talk) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>       |
| e. nutrition information                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>       |
| f. individual meetings with staff               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>       |
| g. post cards or faxes you sent                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>       |
| h. cooking demonstrations                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>       |
| i. experience in sessions with preparing foods  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>       |
| j. receiving low sodium and fat calories foods  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>       |
| k. using the "Food & Fitness Guide"             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>       |
| l. written feedback on food record              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>       |
| m. exercise topics                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>       |
| n. monitoring exercise                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>       |
| o. exercising with the group                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>       |
| p. monthly contact with nutritionist            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>       |
| q. feedback on urine results                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>       |
| r. spouse or other at meetings                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>       |
6. Are you presently attending an exercise class, health club, gym, or spa at least 3 times per week outside of TOHP?  
 Yes  No
7. Did you use home exercise equipment as part of your TOHP weight loss program?  
 Yes  No
8. Did you have a regular physical activity program prior to beginning TOHP?  
 Yes  No
9. How would you describe your current exercise habits compared to what you were doing before you joined TOHP?  
 Increased  Decreased  Stayed the same
10. How many days per week do you currently exercise? \_\_\_\_\_ days per week

11. On the days you get exercise, about how many minutes do you average per day? \_\_\_\_\_ minutes
12. How long have you been following this exercise program? \_\_\_\_\_ weeks
13. Please rank **your 3 top barriers** to physical activity (1= presented biggest barrier) or check the box below to indicate no barriers.

No Barriers

Barriers:

- \_\_\_ lack of time
- \_\_\_ lack of interest
- \_\_\_ lack of motivation
- \_\_\_ lack of encouragement/support
- \_\_\_ lack of energy
- \_\_\_ lack of child care
- \_\_\_ lack of access to exercise facilities
- \_\_\_ lifestyle changes seem too overwhelming
- \_\_\_ exercise benefits are not readily apparent
- \_\_\_ uncertain about what type of exercise should be done
- \_\_\_ physical disability

14. Since joining TOHP, have you tried any of the following approaches to lose weight?

	Have Not Tried	Tried Briefly	Tried when Introduced and Keep Doing
a. a diet that is different from a normal from a normal weight loss diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. increasing routine activities; such as climbing stairs, taking on more active yard work and household activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. taking vitamins, minerals, or multivitamins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. eating meal replacements; such as Ultra Slim Fast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. fasting for 24 hours or longer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. going to a weight loss program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. using hypnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. taking diet pills or appetite suppressants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. taking water pills or fluid pills (diuretics)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. taking hormone products; such as thyroid pills or hormone injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Have Not Tried	Tried Briefly	Tried when Introduced and Keep Doing
m. taking laxatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. causing yourself to vomit after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. eating out less	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. eating only at certain restaurants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. Which of the following best describes your preference for **salty tasting foods** . . .

	Like(d) a lot	Like(d) some	Dislike(d) some	Dislike(d) at lot
Before being TOHP:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Currently:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. Which of the following best describes your preference for **low sodium or unsalted foods**

	Like(d) a lot	Like(d) some	Dislike(d) some	Dislike(d) at lot
Before being TOHP:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Currently:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. Please rank your 3 top barriers to sodium reduced eating patterns below (1= presented biggest barrier) or check the box below to indicate no barriers.

No Barriers

Barriers:

- liking salty foods/snacks
- no low sodium foods at social occasions
- no low sodium foods at home
- food preparation was difficult
- low sodium foods cost too much
- too much thinking and planning required
- shopping took too long
- could not tell if I was getting results
- did not know sodium content of restaurant food
- did not like the taste of food with other seasonings
- hard to stick to low sodium when traveling
- friends/family were not supportive
- could not control food purchase or preparation

18. Since joining TOHP, have you tried any of the following approaches to lower your sodium?

	Have Not Tried	Tried Briefly	Tried for at Least Several Months
a. using a salt substitute	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. limiting use of convenience foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. using low sodium products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. using fresh/frozen, instead of canned, vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. using herbs/spices to season foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. diluting regular food products with low sodium products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. freezing low sodium foods for convenience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. draining/rinsing canned foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. taking low sodium lunch to work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. eating out less	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. reading food labels for sodium	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. keeping count of daily milligrams of sodium	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. "budgeting" for eating high sodium foods by eating low sodium foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. modifying recipes to lower sodium	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. How much did you spend on food during TOHP compared to before TOHP?

- more
- less
- about the same
- do not know

20. Does the amount you spend influence your willingness to continue striving to maintain your combined or weight/sodium program?

- Yes
- No

21. What is the least you have weighed since you were age 18 (not counting periods of illness)?  
\_\_\_\_\_ pounds
22. What is the highest weight after age 18 (excluding pregnancy)? \_\_\_\_\_ pounds
23. When you became a TOHP participant, had you:
- recently lost weight.
  - recently gained weight.
  - been relatively weight stable.
24. How many times have you lost 10 or more pounds intentionally and regained it prior to TOHP (excluding pregnancy and illness)?  
\_\_\_\_\_ times
25. Have you ever considered yourself overweight?
- Yes
  - No
26. If yes, at what age did you first consider yourself overweight?
- childhood
  - adolescence
  - in your 20's
  - age 30 or older

Thank you for providing us with this information. Good health to you.