

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 Weight and Lifestyle Inventory is reprinted here with the permission of the authors. Copyright © 2003 by Thomas A. Wadden and Gary D. Foster, Philadelphia, Pennsylvania.

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.
 2. decreased 5 to 10 lbs.
 3. increased by 1 to 5 lbs.
 4. increased by 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
- How many glasses of wine did you typically drink a week?
 - How many bottles of beer did you typically drink a week?
 - 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 | 4. Contributes a large amount |
| 2. Contributes a small amount | 5. Contributes the greatest amount |
| 3. Contributes a moderate amount | |
-
- | | |
|---|---|
| ___ A. Eating too much food | ___ M. Eating while cooking or preparing food |
| ___ B. Overeating at breakfast | ___ N. Eating when anxious |
| ___ C. Overeating at lunch | ___ O. Eating when tired |
| ___ D. Overeating at dinner | ___ P. Eating when bored |
| ___ E. Snacking between meals | ___ Q. Eating when stressed |
| ___ F. Snacking after dinner | ___ R. Eating when angry |
| ___ G. Eating because I feel physically hungry | ___ S. Eating when depressed/upset |
| ___ H. Eating because I crave certain foods | ___ T. Eating when socializing/celebrating |
| ___ I. Continuing to eat because I don't feel full | ___ U. Eating when happy after a meal |
| ___ J. Eating because I can't stop once I've begun | ___ V. Eating when alone |
| ___ K. Eating because of the good taste of foods | ___ W. Eating with family/friends |
| ___ L. Eating in response to sight or smell of food | ___ 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 d. Four or five days a week
 b. One day a week e. Nearly every day
 c. Two or three days a week
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

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 greater than usual stress 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 during the past 6 months?

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 in the next 6 months, 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 <input type="checkbox"/>	No <input type="checkbox"/>
Angina	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Palpitations, heart beats fast or hard	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Stroke, mild stroke (cerebrovascular accident)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Rheumatic fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart murmur	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pacemaker	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Breathing problems (asthma, lung disease)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
High blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Back problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Joint or bone problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hiatal hernia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Arthritis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Gout (elevated uric acid)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Gallbladder disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Thyroid problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Kidney disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Ulcers	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bowel disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Liver disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes (type I or II)	Yes <input type="checkbox"/>	No <input type="checkbox"/>

