

PATIENT SELF-ASSESSMENT WEIGHT (PSAW) QUESTIONNAIRE

Patient Name _____

Date: _____

Directions: Below a number of situations are described. For each situation, we would like you to tell us which answer represents your feelings most of the time. Circle the most accurate number that represents how you feel when faced with the different scenarios.

	Not Motivated		Very Motivated
1. How motivated are you to reach your desired weight goal.	1	2	3
	4	5	6
	7		

	Harmful		Beneficial
2. Reaching my desired weight goal is....	1	2	3
	4	5	6
	7		

	Unnecessary		Necessary
3. Reaching my desired weight goal is....	1	2	3
	4	5	6
	7		

	Definitively False		Definitively True
4. I am confident that I will reach my desired weight goal.	1	2	3
	4	5	6
	7		

Total Score (Q1-4): _____

	Definitively False		Definitively True
5. I feel very good about myself.	1	2	3
	4	5	6
	7		

	Definitively False		Definitively True
6. I have interest in other people and/or things.	1	2	3
	4	5	6
	7		

Total Score (Q5-6): _____

	Definitively False		Definitively True
7. I have someone to talk to about my personal, family, and/or work problems.	1	2	3
	4	5	6
	7		

	Definitively False		Definitively True
8. I get invitations to go out and socialize with other people.	1	2	3
	4	5	6
	7		

Total Score (Q7-8): _____

	Definitively False		Definitively True
9. I am certain I will continue to perform light physical activity (e.g., walking, hiking, yard work, etc.) three or more days per week.	1	2	3
	4	5	6
	7		

Total Score (Q9): _____

	1	2	3	4	5	6	7
10. On a Scale of 1 to 7, where 1 means no restraint in eating (eating whatever you want, whenever you want) and 7 means total restraint (constantly limiting food intake and never "giving in") what number would you give yourself?							

	Definitively False		Definitively True
11. I find myself eating when I am anxious, angry, depressed, and/or lonely.	7	6	5
	4	3	2
	1		

	Definitively False		Definitively True
12. I am always hungry enough to eat at any time.	7	6	5
	4	3	2
	1		

Total Score (Q10-12): _____

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Directions: Since your last appointment with your medical provider you may have experienced difficulties or barriers that may have limited your ability to achieve your desired weight goal. Please list the barriers below and if you have resolved these barriers.

	Barrier Resolved			
	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
1. _____	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
2. _____	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
3. _____	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
4. _____	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
5. _____	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>

What do you hope to gain from this follow-up appointment with your medical provider?

To be completed by clinic staff

Height: _____ Ft _____ In Weight: _____ LBS Body Mass Index: _____ kg/m²

Waist Circumference: _____ inches Blood Pressure: _____ / _____ mmHg

Resting Metabolic Rate: _____ Kcals/day Other Labs: _____