Child ID

Section I. Child Health

Please fill in Today's Date: ___ ___ / ___ ___ / 20___ ___
MM / DD / YY

1. Has a doctor or other health care provider ever told you that your child has the following conditions? If so, mark YES by putting an X, and fill in the circle to show the year of diagnosis. Please mark your best answer even if you are not sure.

			Year of Diagnosis		
			Before Oct 2015	Oct 2015 to Oct 2016	After Oct 2016
Type 1 Diabetes	No ☐	Yes ☐ →	O	O	O
Type 2 Diabetes	No ☐	Yes ☐ →	O	O	O
High blood pressure (hypertension)	No ☐	Yes ☐ →	O	O	O
Chronic inflammatory disease (like lupus or arthritis)	No ☐	Yes ☐ →	O	O	O
Hay fever or respiratory allergy (to pets, pollens, mold, dust mites, etc.)	No ☐	Yes ☐ →	O	O	O
Obesity	No ☐	Yes ☐ →	O	O	O
Eczema or any kind of skin allergy (like contact dermatitis)	No ☐	Yes ☐ →	O	O	O
Attention Deficit / Hyperactivity Disorder (ADHD)	No ☐	Yes ☐ →	O	O	O
Depression	No ☐	Yes ☐ →	O	O	O
Anxiety	No ☐	Yes ☐ →	O	O	O
Behavior or conduct problems	No ☐	Yes ☐ →	O	O	O
Autism/ Asperger's Disorder or Pervasive Developmental Disorder not otherwise specified	No ☐	Yes ☐ →	O	O	O
Stuttering, stammering, or other speech problems	No ☐	Yes ☐ →	O	O	O
Epilepsy or seizure disorder	No ☐	Yes ☐ →	O	O	O
Hearing problems	No ☐	Yes ☐ →	O	O	O
Vision problems that cannot be corrected with glasses or contact lenses	No ☐	Yes ☐ →	O	O	O
Bone, joint or muscle problems	No ☐	Yes ☐ →	O	O	O
A brain injury or concussion	No ☐	Yes ☐ →	O	O	O
Any developmental delay or intellectual disability	No ☐	Yes ☐ →	O	O	O
Chronic kidney disease, end-stage kidney disease or postrenal transplant	No ☐	Yes ☐ →	O	O	O

			Year of Diagnosis		
			Before Oct 2015	Oct 2015 to Oct 2016	After Oct 2016
A digestive problem (like colitis, acid reflux, colic or Crohn's)	No ☐	Yes ☐ →	O	O	O
Asthma	No ☐	Yes ☐ →	O	O	O
Food allergy	No ☐	Yes ☐ →	O	O	O

Medications

2. In the **PAST YEAR**, has your child taken the following medications? (Select all that apply)

Medications	No	Yes
Antibiotics (For example: Cipro, Zithromax, Amoxil, Cleocin, Levaquin, Keflex, Suprax)	O	O
Cold or flu medications (For example: Advil, Benadryl, Dayquil, Dimetapp, Motrin, Mucinex, Nyquil, Robitussin, Sudafed, Tylenol Flu)	O	O
ADD/ ADHD medications (For example: Adderall, Ritalin, Methylin, Metadate, Strattera, Intuniv, Concerta)	O	O
Behavior medications for Autism or other disorders (For example: Risperdol, Zyprexa, Haldol)	O	O
Inhalers and other asthma drug prescriptions (For example: Pulmicort, Flovent, Singulair, Zyflo, Orapred, Advair, Symbicort, Xolair)	O	O
Prescribed allergy medications, antihistamines, injections (For example: Astelin, Astepro nasal spray, Atarax, Vistaril, Clarinex, Pataday eyedrops, Patanol eyedrops, Optivar eyedrops)	O	O
Over the counter allergy medications (For example: Zyrtec, Claritin, Benadryl, Allegra)	O	O
Depression and Anxiety medications (For example: Prozac, Zoloft, Luvox, Anafranil)	O	O
Pain medications (For example: Tylenol/acetaminophen, Advil)	O	O
Epilepsy medications (For example: Tegretol, Dilantin, Depakote, Zarontin, Neurontin, Topamax, Lamictal, Zonegran)	O	O
Antidiabetic medications (For example: Metformin, Insulin)	O	O
Reflux medications (For example: Prilosec, Prevacid)	O	O
Sleep medications (For example: Melatonin, Ambien, Sonata, Restoril)	O	O

Medications	No	Yes
Stool softeners (For example: Dulcolax, Miralax)	O	O
Other medications (not vitamins or supplements)	O	O If you marked "yes," please write which other medication(s) ________ ________ ________

Bullying and Behavior

3. Please answer the questions presented in the table below regarding bullying. (Please choose **ONE** best answer even if you are unsure.)

In the past few months, how often has your child been:

	Never	Seldom only once or twice	2 or 3 times a month	About once a week	Several times a week
Bullied	O	O	O	O	O
Bullied by insulting, calling names or laughed at	O	O	O	O	O
Bullied by way of spitting, hitting, kicking or pinching	O	O	O	O	O
Bullied by being excluded from activities, ignored by other children or gossiped about	O	O	O	O	O

In the past few months, how often has your child:

	Never	Seldom only once or twice	2 or 3 times a month	About once a week	Several times a week
Bullied other children	O	O	O	O	O
Bullied other children by saying insulting things to them, calling them names or laughing at them	O	O	O	O	O
Bullied other children by spitting at them, hitting them, kicking or pinching them	O	O	O	O	O

	Never	Seldom only once or twice	2 or 3 times a month	About once a week	Several times a week
Bullied other children by excluding them from activities, ignoring them or by gossiping about them	O	O	O	O	O

4. Please think about your child's behaviors in the **past 6 months**. (Please choose **ONE** answer)

	Never	Occasionally	Often	Very often
Does not pay attention to details or makes careless mistakes with, for example, homework	O	O	O	O
Has difficulty keeping attention to what needs to be done	O	O	O	O
Does not seem to listen when spoken to directly	O	O	O	O
Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	O	O	O	O
Has difficulty organizing tasks and activities	O	O	O	O
Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	O	O	O	O
Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	O	O	O	O
Is easily distracted by noises or other stimuli	O	O	O	O
Is forgetful in daily activities	O	O	O	O
Fidgets with hands or feet or squirms in seat	O	O	O	O
Leaves seat when remaining seated is expected	O	O	O	O
Runs about or climbs too much when remaining seated is expected	O	O	O	O
Has difficulty playing or beginning quiet play activities	O	O	O	O
Is "on the go" or often acts as if "driven by a motor"	O	O	O	O
Talks too much	O	O	O	O
Blurts out answers before questions have been completed	O	O	O	O
Has difficulty waiting his or her turn	O	O	O	O
Interrupts or intrudes on others' conversations and/or activities	O	O	O	O
Argues with adults	O	O	O	O
Loses temper	O	O	O	O
Actively defies or refuses to go along with adults' requests or rules	O	O	O	O
Deliberately annoys people	O	O	O	O
Blames others for his or her mistakes or misbehaviors	O	O	O	O
Is touchy or easily annoyed by others	O	O	O	O
Is angry or resentful	O	O	O	O
Is spiteful and wants to get even	O	O	O	O
Bullies, threatens, or intimidates others	O	O	O	O
Starts physical fights	O	O	O	O
Lies to get out of trouble or to avoid obligations ("cons" others)	O	O	O	O

Child ID

	Never	Occasionally	Often	Very Often
Skips school without permission	O	O	O	O
Is physically cruel to people	O	O	O	O
Has stolen things that have value	O	O	O	O
Deliberately destroys others' property	O	O	O	O
Has used a weapon that can cause serious harm (i.e., bat, knife, ~~brick,~~ gun)	O	O	O	O
Is physically cruel to animals	O	O	O	O
Is fearful, anxious, or worried	O	O	O	O
Is afraid to try new things for fear of making mistakes	O	O	O	O
Feels worthless or inferior	O	O	O	O
Blames self for problems, feels guilty	O	O	O	O
Feels lonely, unwanted, or unloved; complains that "no one loves" him or her	O	O	O	O
Is sad, unhappy, or depressed	O	O	O	O
Is self-conscious or easily embarrassed	O	O	O	O

5. Please indicate how well your child is doing in school. (Please choose **ONE** answer and skip the item if not applicable such as for siblings.)

Performance	**Excellent**	**Above Average**	**Average**	**Somewhat of a problem**	**Problematic**
Overall school performance	O	O	O	O	O
Reading	O	O	O	O	O
Writing	O	O	O	O	O
Mathematics	O	O	O	O	O
Relationship with parents	O	O	O	O	O
Relationship with siblings	O	O	O	O	O
Relationship with peers	O	O	O	O	O
Participation in organized activities (example, teams)	O	O	O	O	O

Physical Activity

6. Which of the following activities did your child do during the **PAST WEEK**?

> ***Please complete every line*** *below, placing an "X" in the box next to either "No" if your child did not participate in that particular activity or "Yes" if your child did participate in that particular activity. If you indicate "yes," please estimate the number of hours and minutes your child did the activity during the* ***PAST WEEK****.*

Does your child do this activity (answer "Yes" or "No" and for how long (answer in hours and minutes))?	**No**	**Yes**	**Total WEEKLY time spent in activity *(Hours and Minutes)***
Aerobics	☐	☐ →	______Hrs ______Mins

6. Which of the following activities did your child do during the **PAST WEEK**?

__Please complete every line__ below, placing an "X" in the box next to either "No" if your child did not participate in that particular activity or "Yes" if your child did participate in that particular activity. If you indicate "yes," please estimate the number of hours and minutes your child did the activity during the __PAST WEEK__.

Does your child do this activity (answer "Yes" or "No" and for how long (answer in hours and minutes))?	**No**	**Yes**	**Total WEEKLY time spent in activity *(Hours and Minutes)***
Baseball or softball	☐	☐ →	______Hrs ______Mins
Basketball or volleyball	☐	☐ →	______Hrs ______Mins
Dancing	☐	☐ →	______Hrs ______Mins
Soccer	☐	☐ →	______Hrs ______Mins
Gymnastics	☐	☐ →	______Hrs ______Mins
Hockey (field or ice)	☐	☐ →	______Hrs ______Mins
Martial Arts (such as Karate, Taekwondo, Judo, kickboxing)	☐	☐ →	______Hrs ______Mins
American football	☐	☐ →	______Hrs ______Mins
Jogging or running (not as part of playing tag or other games or recess)	☐	☐ →	______Hrs ______Mins
Swimming	☐	☐ →	______Hrs ______Mins
Tennis, squash or badminton	☐	☐ →	______Hrs ______Mins
LEISURE ACTIVITIES	**No**	**Yes**	
Bike riding (not school travel)	☐	☐ →	______Hrs ______Mins
Bouncing on trampoline	☐	☐ →	______Hrs ______Mins
Household chores	☐	☐ →	______Hrs ______Mins
Playing in a play house or on a playground	☐	☐ →	______Hrs ______Mins
Playing with or walking pets	☐	☐ →	______Hrs ______Mins
Rollerblading, skating, skateboarding or scooter (not motorized)	☐	☐ →	______Hrs ______Mins
Skiing, snowboarding or sledding	☐	☐ →	______Hrs ______Mins
Skipping rope	☐	☐ →	______Hrs ______Mins
Playing tag	☐	☐ →	______Hrs ______Mins
ACTIVITIES AT SCHOOL	**No**	**Yes**	
Physical Education/ Gym class	☐	☐ →	______Hrs ______Mins
Walking to and from school	☐	☐ →	______Hrs ______Mins

6. Which of the following activities did your child do during the **PAST WEEK**?

__Please complete every line__ below, placing an "X" in the box next to either "No" if your child did not participate in that particular activity or "Yes" if your child did participate in that particular activity. If you indicate "yes," please estimate the number of hours and minutes your child did the activity during the __PAST WEEK__.

Does your child do this activity (answer "Yes" or "No" and for how long (answer in hours and minutes))?	**No**	**Yes**	**Total WEEKLY time spent in activity *(Hours and Minutes)***
Biking to and from school	☐	☐ →	______Hrs ______Mins
Traveling by car or bus to and from school	☐	☐ →	______Hrs ______Mins
Recess	☐	☐ →	______Hrs ______Mins
OTHER ACTIVITIES	**No**	**Yes**	
Playing video games on a game console (such as Wii, PlayStation, Xbox)	☐	☐ →	______Hrs ______Mins
Using computer/internet	☐	☐ →	______Hrs ______Mins
Watching TV/movies	☐	☐ →	______Hrs ______Mins
Playing indoors with toys	☐	☐ →	______Hrs ______Mins
Playing board games/cards	☐	☐ →	______Hrs ______Mins
Arts & crafts (such as drawing and painting)	☐	☐ →	______Hrs ______Mins
Homework	☐	☐ →	______Hrs ______Mins
Imaginary play	☐	☐ →	______Hrs ______Mins
Playing a music instrument	☐	☐ →	______Hrs ______Mins
Reading	☐	☐ →	______Hrs ______Mins
Talking on the phone	☐	☐ →	______Hrs ______Mins

7. If your child plays video games, how often **were these active games requiring motion**? (for example, Wii Sports, Just Dance, Guitar Hero, Kinect Sports)
(Place an "X" through the box of the SINGLE best answer)

☐ Never
☐ Rarely
☐ Occasionally
☐ Frequently
☐ Almost all the time
☐ My child does not play video games

8. Does your child have a…
   (*FOR EACH ITEM, place an "X" through the box of the SINGLE best answer*)

	No	Yes
TV in bedroom?	☐	☐
computer in bedroom?	☐	☐
tablet (e.g., iPad, Nexus, Kindle)?	☐	☐
phone with access to internet (Smartphone)?	☐	☐
cell phone (just for calling)?	☐	☐

Growth

9. If your child was measured by a doctor, school nurse or other health professional, please write down the weight, height and blood pressure (as available) from the most recent visit. Please include your child's age (in years) and the actual date of check-up. If you cannot remember the complete date, please provide as much of the date as you can remember.

Child's Age at Visit (years)	Date of Visit	Height (feet and inches)	Weight (pounds)	Blood Pressure (mmHg)
________ years	____/____/______ MM/DD/YYYY	_______ feet _______ inches	_______ pounds	__________/__________ SBP mmHg/ DBP mmHg
				(Example, 95 mmHg/55 mmHg)

Now we want to ask a few questions that will involve measuring your child.

10. How much does your child weigh now (without shoes)?
    Please place your child on a scale.
    ______________ pounds ☐ I do not own a scale.

11. How tall is your child now (without shoes)?
    Please use the tape measure mailed to you to measure your child's height. Have your child back up to a wall with the back of the head, shoulder blades, buttocks/bottom, and heels touching the wall. Lay a hard-backed book or other flat item from your child's head to the wall and level with the floor. Mark the wall under the book with your finger and then measure from the mark to the floor. Please write the height to the ***nearest inch****.*

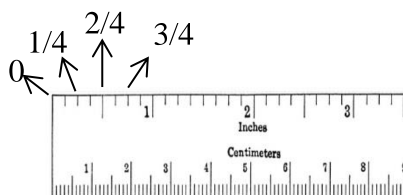
    _______________inches

12. Please use the tape measure to measure your child's waist, following the instructions below:
    a. *Have your child stand upright with feet about shoulder's width apart (about 6 inches). Have your child hold up his/her shirt or other clothing so you can see the waist area.*
    b. *Have your child bend to one side of his/her body while looking straight ahead.*
    c. *The crease that naturally forms when your child bends is the natural waistline. Mark it with your finger.*
    d. *Now tell your child to stand up straight while continuing to keep your finger marking where the crease was. Make sure your child is looking straight ahead and is breathing normally (i.e. not sucking in the stomach).*

e. *Measure the waist at the same level of the crease (representing the natural waist line) by wrapping the tape measure once around with it parallel to the ground. The tape measure should be against the skin but not squeezing it.*

f. *Mark the waist circumference in INCHES and to the closest ¼ inch (i.e. 0, ¼, 2/4, or ¾) and record below.*

Waist	
____________	______/_4_____
Inches	Fraction



Vision

13. Did your child have an eye exam in the PAST year?
☐ Yes ☐ No → skip to question 15

14. What prompted you to bring your child to the eye doctor? (Select all that apply)
☐ School recommended
☐ My child's teacher recommended
☐ My child's doctor recommended
☐ Vision problems run in our family
☐ Routine check-up

15. Does your child need glasses?
☐ Yes ☐ No

16. What was your child's visual acuity (without glasses/ contact lenses)?

Right eye _____ / _____ and Left eye ____ / ____ (For example, 20/20 for one eye)

17. Has your child ever been told by a health care provider that he/she has had the following eye conditions? If so, please mark YES and provide the age when first told of the condition. If not, mark NO.

	Ever diagnosed	Child's age when first diagnosed
Difficulty seeing far away (near-sighted)	No ☐ Yes ☐ →	______years
Difficulty seeing close up (far-sighted)	No ☐ Yes ☐ →	______years
Astigmatism	No ☐ Yes ☐ →	______years
Amblyopia ("Lazy eye")	No ☐ Yes ☐ →	______years
Color-blindness	No ☐ Yes ☐ →	______years
Cataract(s)	No ☐ Yes ☐ →	_____years

Dental Hygiene

18. Was your child ever diagnosed with…

	Ever diagnosed	Child's age when first diagnosed
Cavities (if so, how many? ___)	No ☐ Yes☐ →	_____years
Gingivitis	No ☐ Yes☐ →	_____years
Periodontitis	No ☐ Yes☐ →	_____years

19. Did your child visit the dentist this **PAST YEAR**?

☐ Yes ☐ No

Child Eating Behaviors

20. Please read the following statements about your child's eating and check the boxes most appropriate to your child's eating behavior.

	Never	Rarely	Sometimes	Often	Always
My child loves food	O	O	O	O	O
My child eats more when worried	O	O	O	O	O
My child has a big appetite	O	O	O	O	O
My child finishes his/her meal quickly	O	O	O	O	O
My child is interested in food	O	O	O	O	O
My child is always asking for a drink	O	O	O	O	O
My child refuses new foods at first	O	O	O	O	O
My child eats slowly	O	O	O	O	O
My child eats less when angry	O	O	O	O	O
My child enjoys tasting new foods	O	O	O	O	O
My child eats less when s/he is tired	O	O	O	O	O
My child is always asking for food	O	O	O	O	O
My child eats more when annoyed	O	O	O	O	O
If allowed to, my child would eat too much	O	O	O	O	O
My child eats more when anxious	O	O	O	O	O
My child enjoys a wide variety of foods	O	O	O	O	O
My child leaves food on his/her plate at the end of a meal	O	O	O	O	O
My child takes more than 30 minutes to finish a meal	O	O	O	O	O
Given the choice, my child would eat most of the time	O	O	O	O	O
My child looks forward to mealtimes	O	O	O	O	O
My child gets full before his/her meal is finished	O	O	O	O	O

	Never	Rarely	Sometimes	Often	Always
My child enjoys eating	O	O	O	O	O
My child eats more when s/he is happy	O	O	O	O	O
My child is difficult to please with meals	O	O	O	O	O
My child eats less when upset	O	O	O	O	O
My child gets filled up easily	O	O	O	O	O
My child eats more when s/he has nothing else to do	O	O	O	O	O
Even if my child is full s/he finds room to eat his/her favorite food	O	O	O	O	O
If given the chance, my child would drink continuously throughout the day	O	O	O	O	O
My child cannot eat a meal if s/he has had a snack just before	O	O	O	O	O
If given the chance, my child would always be having a drink	O	O	O	O	O
My child is interested in tasting food s/he hasn't tasted before	O	O	O	O	O
My child decides that s/he doesn't like a food, even without tasting it	O	O	O	O	O
If given the chance, my child would always have food in his/her mouth	O	O	O	O	O
My child eats more and more slowly during the course of a meal	O	O	O	O	O

21. Please read the following statements about meals and choose the ONE most appropriate.

	Never or rarely	Less than once a week	Once a week	2-3 times a week	4-6 times a week	Every day
How often in the past few months did your child eat breakfast at home?	O	O	O	O	O	O
How often did your child eat dinner while watching the TV?	O	O	O	O	O	O
How often did your child eat snacks while watching TV?	O	O	O	O	O	O
How often did your child eat take-out or fast food at home and away from home?	O	O	O	O	O	O
How often did you take your child to fast food restaurants?	O	O	O	O	O	O
How often did you provide money to your child for buying snacks, etc.?	O	O	O	O	O	O

22. How often are the following items available in your child's home?

	Never or rarely	Sometimes	Often	Always
Potato chips or other salty snack foods	O	O	O	O
Chocolate or candies	O	O	O	O
Non-diet soft drinks	O	O	O	O
Diet soft drinks	O	O	O	O

23. Does your child drink water?
☐ Yes ☐ No → skip to question #26

24. If yes, what is the <u>usual</u> source of drinking water?
- ☐ Bottled water
- ☐ Tap water from private well
- ☐ Tap water from the public water system
- ☐ Filtered tap water (Brita or home faucet filter)

25. If using filtered water, what is your water source?
- ☐ Private well
- ☐ Public water system
- ☐ Not sure

Section II. Maternal Health

We also wanted to know how you are doing and ask some questions related to your eating habits.

26. What is YOUR current weight (in pounds)? ___________________ pounds

<u>Medical History</u>

27. What is your current systolic blood pressure (if checked within the PAST 2 years):

Systolic blood pressure (the top number given and the higher number):
(Place an "X" through the box of the SINGLE best answer)

- ☐ Unknown/not checked within 2 years
- ☐ <120 mmHg (normal)
- ☐ 120-139 mmHg (borderline high)
- ☐ ≥140 mmHg (high blood pressure)

28. What is your current diastolic blood pressure (the bottom and lower of the two numbers):
(Place an "X" through the box of the SINGLE best answer)

☐ Unknown/not checked within 2 years
☐ <80 mmHg (normal)
☐ 80-89 (borderline high)
☐ ≥90 (high blood pressure)

29. Do you currently take any medications to lower your blood pressure?
(Place an "X" through the box of the SINGLE best answer)

☐Yes
☐No

30. When was the last time your doctor measured your cholesterol?
(Place an "X" through the box of the SINGLE best answer)

☐ Within the past year
☐ Less than 2 years ago
☐ 2 years or more ago
☐ Never have checked

31. Do you take any medications for high cholesterol (such a Lipitor, Lescol, Crestor, Zocor, Mevacor, Pravachol or any others)?
(Place an "X" through the box of the SINGLE best answer)

☐Yes
☐No

Eating and Other Behaviors

32. For the PAST 7 DAYS, how many days did all or most of the family living in your home eat the main meal together?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

The following questions ask about your eating habits in the past year. People sometimes have difficulty controlling their intake of certain foods such as sweets, starches, salty snacks, fatty foods, sugary drinks, and others.

33. In the past 12 MONTHS, how often were each of these statements true for you?

	Never	**Once per month**	**2-4 times per month**	**2-3 times per week**	**4+ times per week**
I find myself consuming certain foods even though I am no longer hungry	O	O	O	O	O
I worry about cutting down on certain foods	O	O	O	O	O
I feel sluggish or fatigued from overeating	O	O	O	O	O

	Never	Once per month	2-4 times per month	2-3 times per week	4+ times per week
I have spent time dealing with negative feelings from overeating certain foods, instead of spending time in important activities such as time with family, friends, work, or recreation	O	O	O	O	O
I have had physical withdrawal symptoms such as agitation and anxiety when I cut down on certain foods (Do NOT include caffeinated drinks: coffee, tea, cola, energy drinks, etc.)	O	O	O	O	O
My behavior with respect to food and eating causes me significant distress	O	O	O	O	O
Issues related to food and eating decrease my ability to function effectively (daily routine, job/school, social or family activities, health difficulties)	O	O	O	O	O

34. In the past 12 MONTHS:

	No	Yes	Not applicable
I kept consuming the same types or amounts of food despite significant emotional and/or physical problems related to my eating	O	O	O
Eating the same amount of food does not reduce negative emotions or increase pleasurable feelings the way it used to	O	O	O

35. Please choose **ONE** response that best expresses how well each statement describes you for each statement below.

	Not at all	Slightly	More or less	Pretty well	Completely
I purposely hold back at meals in order not to gain weight.	O	O	O	O	O
I tend to eat more when I am anxious, worried, or tense.	O	O	O	O	O
I count calories as a conscious mean of controlling weight.	O	O	O	O	O
When I feel lonely I console myself by eating.	O	O	O	O	O
I tend to eat more food than usual when I have more available places that serve or sell food.	O	O	O	O	O
I tend to eat when I am disappointed or feel let down.	O	O	O	O	O

	Not at all	Slightly	More or less	Pretty well	Completely
If I see others eating, I have a strong desire to eat too.	O	O	O	O	O
Some foods taste so good I eat more even when I am no longer hungry.	O	O	O	O	O
When I have eaten too much during the day, I will often eat less than usual the following day.	O	O	O	O	O
I often eat so quickly I don't notice I'm full until I've eaten too much.	O	O	O	O	O
If I eat more than usual during a meal, I try to make up for it at another meal.	O	O	O	O	O
When I am offered delicious food, it's hard to resist eating it even if I've just eaten.	O	O	O	O	O
I eat more when I am having relationship problems.	O	O	O	O	O
When I am under a lot of stress, I eat more than I usually do.	O	O	O	O	O
When I know I'll be eating a big meal during the day, I try to make up for it by eating less before or after that meal.	O	O	O	O	O

36. Choose one response that best describes how strongly each item applies to you.

	Definitely Agree	Slightly Agree	Slightly Disagree	Definitely Disagree
I often notice small sounds when others do not.	O	O	O	O
When I'm reading a story, I find it difficult to work out the characters' intentions.	O	O	O	O
I find it easy to "read between the lines" when someone is talking to me.	O	O	O	O
I usually concentrate more on the whole picture, rather than on the small details.	O	O	O	O
I know how to tell if someone listening to me is getting bored.	O	O	O	O
I find it easy to do more than one thing at once.	O	O	O	O
I find it easy to work out what someone is thinking or feeling just by looking at their face.	O	O	O	O

	Definitely Agree	Slightly Agree	Slightly Disagree	Definitely Disagree
I like to collect information about categories of things (e.g., types of cars, birds, trains, plants).	O	O	O	O
I find it difficult to work out people's intentions.	O	O	O	O

Thank you very much for your time!