CLOCKS PROGRAM PARTICIPANT STUDY FORM

DEMOGRAPHICS

(LAST) *(FIRST)* *(MIDDLE INITIAL)*

1 Patient Name:

2 Present Address: **Street or PO Box** _____

City _____ **State**_____ **Zip Code** _____

County _____

3 Residence Location: **City** ☐ **Suburb** ☐ **Rural** ☐

4 Residence: **House** ☐ **Apartment** ☐ **Mobile Home** ☐ **Shelter** ☐ **Homeless** ☐

5 Place of Birth: **City** _____ **State** _____

County _____ **Country** _____

6 Date of Birth: **Month** ☐☐ **Day** ☐☐ **Year** ☐☐☐☐ | **7 Sex: Male** ☐ **Female** ☐

8 Race/Ethnicity: **White, Not Hispanic** ☐ **White, Hispanic** ☐ **American Indian,Alaskan Native** ☐

Black, Not Hispanic ☐ **Black, Hispanic** ☐ **Indian, Middle Eastern** ☐

Asian ☐ **Pacific Islander** ☐ **Not Specified** _____

9 If not born in the U. S., Date entered U. S.: **Month** ☐☐ **Year** ☐☐☐☐

10 Health Insurance: **Medicaid, State** ☐ **Medicare, Federal** ☐ **PPO, HMO, Private** ☐ **None** ☐

11 Highest Level of Education Completed: **Elementary School** ☐ **Middle School** ☐

High School ☐ **Technical School** ☐ **Associate Degree** ☐

Bachelor Degree ☐ **Masters Degree** ☐

Doctorate Degree ☐

12 Household Income Range:

$0 - $9,999 ☐	**$10,000 - $19,999** ☐	**$20,000 - $29,000** ☐
$30,000 - $39,999 ☐	**$40,000 - $49,999** ☐	**$50,000 - $59,999** ☐
$60,000 - $79,999 ☐	**$80,000 - $99,999** ☐	**≥ $100,000** ☐

ACCESS TO HEALTH CARE & HEALTHCARE INFORMATION

13 Are you able to read? Yes ☐ **No** ☐

(If yes, skip to 15)

14 If not, do you have someone who reads to you

Yes ☐ **No** ☐

15 Do you have a primary health care provider? Yes ☐ **No** ☐ ***(If no, skip to* 21)**

16 How many miles do you travel to obtain primary health care? _____

17 Does your primary health care provider address your weight? Yes ☐ **No** ☐

18 Do you believe that your primary health care provider gives you adequate information regarding attaining or maintaining a healthy weight? Yes ☐ No ☐

19 In regard to attaining or maintaining a healthy weight, does your primary health care provider give you: Verbal information ☐ Written information ☐ Both ☐

20 Is written information provided to you by your primary health care provider regarding attaining or maintaining a healthy weight easy to read and understand?
Yes ☐ No ☐ Not Applicable ☐

21 Do you have access to the internet? ***(If no, skip to 26)***
Yes ☐ No ☐

22 How do you access the internet?
Computer ☐ Cell phone ☐ Both ☐

23 Do you use the internet to obtain information on:
Diets ☐ Healthy recipes ☐ Eating guidelines ☐ Exercise guidelines ☐ BMI calculators ☐
Weight loss tools ☐ Other ☐ _____

24 Do you believe the information you obtain from the internet on weight loss and exercise Is accurate?
Yes ☐ No ☐ If no, why not? _____

25 What top three websites are particularly useful to you for attaining weight loss and exercise information?
a. _____
b. _____
c. _____

HEALTH STATUS

26 Height: ☐ feet ☐ inches | **27 Weight: ☐ pounds ☐ ounces** | **28 BMI: _____**

29 Do you believe that you are overweight?
Yes ☐ No ☐

30 If you are or believe you are overweight, at what age do you recall becoming overweight? _____

31 Do you believe healthy eating costs more than eating fast food or boxed/processed foods?
Yes ☐ No ☐

32 On average, how much do you spend each week for your household on food purchased from:
Fast food? _____
Grocery store? _____

33 Do you believe that you follow the recommended government:
Eating guidelines Yes ☐ No ☐
Exercise guidelines Yes ☐ No ☐

34 When was your last Hemoglobin (Hgb) A1C assessed?
In the last 3 months ☐ In the last year ☐
Never ☐

35 What was the last blood pressure reading you remember obtaining? _____/_____	**36 Do you have your cholesterol level checked at least once per year? Yes ☐ No ☐**

37 Do you have a family history of any of the following health conditions: ***(Select all that apply.)***

Diabetes Mellitus Type 2 ☐ Hypertension ☐ Coronary Artery Disease ☐ High cholesterol ☐
Chronic Kidney Disease ☐ Fatty Liver Disease ☐ Stroke ☐ Sleep Apnea ☐ Osteoarthritis ☐
Cancer ☐ If so, type:_____ Infertility ☐ Gallbladder Disease ☐ Polycystic Ovaries ☐
Depression ☐ Obesity ☐
Problems with pregnancy ☐ If so, describe: _____

38 Have you been diagnosed with any of the following health conditions: ***(Select all that apply.)***

Diabetes Mellitus Type 2 ☐ Hypertension ☐ Coronary Artery Disease ☐ High cholesterol ☐
Chronic Kidney Disease ☐ Fatty Liver Disease ☐ Stroke ☐ Sleep Apnea ☐ Osteoarthritis ☐
Cancer ☐ If so, type:_____ Infertility ☐ Gallbladder Disease ☐ Polycystic Ovaries ☐
Obesity ☐ Depression ☐
Problems with pregnancy ☐ If so, describe: _____

39 What over-the-counter and prescription medications do you take on a regular basis?

DIET LIFESTYLE

40 How many meals per day do you eat? _____	**41 How many snacks per day do you eat? _____**
42 What does a typical breakfast include:	**43 What does a typical lunch include:**
44 What does a typical dinner/supper include:	**45 What do snacks typically include:**
46 Are you currently dieting? Yes ☐ No ☐ (***If no, skip to 48***)	**47 What type of diet are you following?**

48 Have you ever followed any of these diet plans: ***(Select all that apply.)***

Weight Watchers ☐ Atkins ☐ Ketogenic ☐ Jenny Craig ☐ Nutri-System ☐
Metabolic Research ☐ Intermittent Fasting ☐ Liquid-based ☐ South Beach ☐
Paleo ☐ Blood Type ☐ Mediterranean ☐ Other ☐ type:_____

49 Have you ever or are you currently taking any over-the-counter medications or prescription medications to assist you with losing weight? If so, please list:

50 If you followed or are following any type of diet plan, were you successful? Yes ☐ No ☐

51 If you were successful, have you maintained your weight loss? Yes ☐ No ☐

52 If you were not successful or did not maintain your weight loss, what do you believe were the reason(s):

53 If you know, about how many calories do you consume each day? _____

If you know, about how many carbohydrates do you consume each day? _____

54 How many calories do you think you should consume daily to lose weight? _____

How many carbohydrates do you think you should consume daily to lose weight? _____

55 Which do you think is the most important to follow when trying to lose weight?

Decreased calorie intake ☐ Decreased carbohydrate (sugar) intake ☐ Decreased fat intake ☐

EXERCISE LIFESTYLE

56 Do you consider your daily activity levels to be: light ☐ moderate ☐ intense ☐

- **Light examples:** walking slowly (i.e. shopping, walking around the office), making the bed, preparing food, and washing dishes.
- **Moderate examples:** sweeping the floor, walking briskly, slow dancing, vacuuming, washing windows, shooting a basketball.
- **Intense examples:** running (> 5 mph), swimming, shoveling, soccer, jumping rope, carrying heavy loads (i.e. bricks).

57 Do you consider yourself to be fairly sedentary, meaning you sit or lie down for much of every day?

Yes ☐ No ☐

58 Do you complete planned exerecise activities that increase your heart rate and last at least 30 minutes each time? Yes ☐ No ☐ ***(If no, skip to 62)***

59 How many days per week do you complete exercise that increases your heart rate and lasts at least 30 minutes each time? _____

60 On which days of the week do you typically complete planned exercise that increases your heart rate and lasts at least 30 minutes each time?

Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday ☐

61 What types of planned exercise activities do you participate in:

Sports ☐ Walking ☐ Jogging/Running ☐ Aerobics/Dancing ☐ Swimming ☐

Weight lifting ☐ Strength training ☐ Yoga/Pilates ☐ Bicycling ☐ Marshial Arts ☐

Other ☐ types _____

GENERAL LIFESTYLE QUESTIONS

62 How many hours per night of sleep do you get?

63 How much stress do you believe you feel on a daily basis?

64 Do you have a good support network?

65 Do you use tobacco products? If so, type: _____ How much: _____ How often: _____

If you quit using tobacco products: How long did you use them? _____ Quit Date: _____

66 Do you drink alcohol? Never ☐ If so, how much _____ drinks How often _____

67 How many 8 ounce glasses of water do you consume daily? _____