



About Eating

Please put a **cross** through one box for each question, in black pen, like so:



	Not at all	Slightly	Moderately	Extremely			
Q1a Have you ever felt fat?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Q1b Have you ever had a definite fear that you might gain weight or become fat?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Q1c Has your weight ever influenced how you think about (judge) yourself as a person?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Q1d Has your shape ever influenced how you think about (judge) yourself as a person?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Q2 Have there ever been times when you felt you have eaten what other people would regard as an unusually large amount of food (e.g., a whole tub of ice cream) given the circumstances?					Yes <input type="checkbox"/>		No <input type="checkbox"/>
If yes, continue. If no, go to Q3 over the page.							
Q2a During the times when you ate an unusually large amount of food, did you experience a loss of control (feel you couldn't stop eating or control what or how much you were eating)?					Yes <input type="checkbox"/>		No <input type="checkbox"/>
If yes, continue. If no, go to Q3 over the page.							
Q2a(i) At its worst, how many DAYS per week on average did you eat an unusually large amount of food and experience a loss of control?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
Q2a(ii) At its worst, how many TIMES per week on average did you eat an unusually large amount of food and experience a loss of control?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
	8 <input type="checkbox"/>	9 <input type="checkbox"/>	10 <input type="checkbox"/>	11 <input type="checkbox"/>	12 <input type="checkbox"/>	13 <input type="checkbox"/>	14 <input type="checkbox"/>
Q2a(iii) Did you eat much more rapidly than normal?					Yes <input type="checkbox"/>		No <input type="checkbox"/>
Q2a(iv) Did you eat until you felt uncomfortably full?					Yes <input type="checkbox"/>		No <input type="checkbox"/>
Q2a(v) Did you eat large amounts of food when you didn't feel physically hungry?					Yes <input type="checkbox"/>		No <input type="checkbox"/>
Q2a(vi) Did you eat alone because you were embarrassed by how much you were eating?					Yes <input type="checkbox"/>		No <input type="checkbox"/>
Q2a(vii) Feel disgusted with yourself, depressed, or very guilty after overeating?					Yes <input type="checkbox"/>		No <input type="checkbox"/>
Q2a(viii) Feel very upset about your uncontrollable overeating or resulting weight gain?					Yes <input type="checkbox"/>		No <input type="checkbox"/>

please turn over...

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Q3 Have you ever made yourself vomit to prevent weight gain or counteract the effects of eating? Yes ☐ No ☐

If yes, continue. If no go to Q4 below.

Q3a At its worst, how many times per week on average did you make yourself vomit to prevent weight gain or counteract the effects of eating? 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐
8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐

Q4 Have you ever used laxatives or diuretics to prevent weight gain or counteract the effects of eating? Yes ☐ No ☐

If yes, continue. If no go to Q5 below.

Q4a At its worst, how many times per week on average have you used laxatives or diuretics to prevent weight gain or counteract the effects of eating? 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐
8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐

Q5 Have you ever fasted (skipped at least 2 meals in a row) to prevent weight gain or counteract the effects of eating? Yes ☐ No ☐

If yes, continue. If no go to Q6 below.

Q5a At its worst, how many times per week on average did you fast (skip at least 2 meals in a row) to prevent weight gain or counteract the effects of eating? 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐
8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐

Q6 Have you ever engaged in excessive exercise specifically to counteract the effects of overeating episodes? Yes ☐ No ☐

If yes, continue. If no go to Q7 below.

Q6a At its worst, how many times per week on average have you engaged in excessive exercise specifically to counteract the effects of overeating episodes? 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐
8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐

Q7 How tall are you? feet inches
OR cm

Q8 What was your **lowest** weight at this height? stones lbs
OR kg
OR Dont know (cross box) ☐

Thank you for taking the time to complete this questionnaire

When completed, please send this back in the freepost envelope provided to:

Children of the Nineties - ALSPAC,
Oakfield House, 15-23 Oakfield Grove, Bristol, BS8 2BN

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