Prenatal Eating Behaviors Screening (PEBS) Tool

For the questions below, think about how frequently you think or agree with the following items. Mark the box that best describes you for each item.

During this pregnancy, how frequently, if at all...	**1** Never	**2** Rarely (once or twice)	**3** Occasionally (every few weeks/monthly)	**4** A moderate amount (weekly)	**5** A great deal (daily)
1. Have you used any pregnancy symptoms to control weight? (e.g., morning sickness, nausea, etc.)					
2. Have you used diuretics, laxatives, or detox supplements to control your weight or shape in response to food intake? (e.g., probiotics, metabolism boosters, Lasix, etc.)					
3. Have you made yourself sick after eating in order to control your weight or shape?					
4. Did you excessively exercise as a response to food intake? (e.g., to influence weight or shape)					
5. Did you avoid eating any foods which you like in order to influence your shape or weight?					
6. Did you think of trying to vomit in order to lose weight?					
7. Did you experience a loss of control in overeating unrelated to pregnancy cravings?					
8. Did you go on eating binges where you felt that you could not stop?					
9. Did you feel you couldn't control what you were eating and/or excessively exercise in order to control your weight?					
10. Has thinking about your shape or weight interfered with your ability to concentrate on things?					
11. Have you restricted your portion sizes?					
During this pregnancy, how strongly do you agree that...	**1** Strongly disagree	**2** Disagree	**3** Neither agree nor disagree	**4** Agree	**5** Strongly agree
12. You have had the desire for your stomach to feel hungry.					
Sum of Each Column=					
Total Score=					