**Scoring for each item is presented in bold brackets or below item**

**General information**

1. Age\_\_\_\_\_\_\_\_\_\_\_\_\_ years old.
2. Sex: Male ( ) Female ( )
3. Body height\_\_\_\_\_\_\_\_\_\_\_\_\_cm.
4. Body mass\_\_\_\_\_\_\_\_\_\_\_\_\_kilograms.
5. What combat sport did you practice throughout your career? \_\_\_\_\_\_\_\_\_\_\_\_\_
6. At what age did you begin to practice? \_\_\_\_\_\_\_\_\_\_\_\_\_years old.
7. The weight category in which you achieved the best results? \_\_\_\_\_\_\_\_\_\_\_\_\_ kg.
8. The most relevant result in the senior-level competition during your career:
9. No relevant results in the senior-level competition
10. Medal at the provincial championship
11. Medal at the regional championship
12. Medal at the national championship
13. Medal at the high-level international tournament (continental cup, continental open, grand prix, grand slam, masters)
14. Medal at a continental championship
15. World championship and/or Olympic Games
16. Were you able to achieve a similar or even better result in another weight category? Yes ( ) No ( ).
17. In which weight category/categories would you achieve a similar or even better result?\_\_\_\_\_\_\_\_\_\_\_\_kg
18. Have you ever practiced RWL before competition? Yes ( ) No ( )

If your answer is NO, please skip to the Current lifestyle information section.

**Weight cycling information**

1. At what age did you last practice weight cutting preparing for competition? \_\_\_\_\_\_\_\_\_\_\_\_\_years old.
2. How many times per year did you cut weight before competition during your senior-level career? \_\_\_\_\_\_\_\_\_\_\_\_\_(times)
3. How many years did you practice weight cutting before the competition? \_\_\_\_\_\_\_\_\_\_\_\_\_(years)
4. What was the average weight that you usually cut before competitions? \_\_\_\_\_\_\_\_\_\_\_\_\_(kilograms)
5. What is the most weight that you have cut before competitions? \_\_\_\_\_\_\_\_\_\_\_\_\_(kilograms)
6. In how many days did you usually cut weight before competitions? \_\_\_\_\_\_\_\_\_\_\_\_\_days
7. At what age did you begin to cut weight before the competition? \_\_\_\_\_\_\_\_\_\_\_\_\_years old

**Weight Cycling Methods**

1. Which methods did you use to lose weight before the competition? (check more than one if needed)
2. Gradual dieting (weight loss in 2 or more weeks) **(0)**
3. Skipping 1 or 2 meals **(1)**
4. Fasting (all day without meals) **(1)**
5. Restricting fluid ingestion **(1)**
6. Increased exercise (more than usual) **(0)**
7. Training intentionally in heated training rooms **(1)**
8. Saunas **(1)**
9. Training with rubber/plastic suits **(1)**
10. Use winter or plastic suits all day and/or night (without exercise) **(1)**
11. Spitting **(1)**
12. Laxatives **(2)**
13. Diuretics **(2)**
14. Diet pills **(2)**
15. Vomiting **(2)**
16. Hot tube **(1)**
17. Water overloading **(1)**
18. Other

**Current lifestyle information**

**Godin-Shephard Leisure-Time Physical Activity Questionnaire (GSLTPAQ)**

1. During a typical 7-Day period (a week), how many times on average do you do the following kinds of exercise for more than 15 minutes during your free time (write on each line the appropriate number)?
2. Strenuous exercise (heart beats rapidly) (e.g., running, hockey, football, soccer, squash, basketball, cross country skiing, judo, roller skating) \_\_\_\_\_\_\_\_\_\_\_\_\_(times per week)
3. Moderate exercise (not exhausting) (e.g., fast walking, baseball, tennis, bicycling, volleyball, badminton, swimming, alpine skiing, dancing) \_\_\_\_\_\_\_\_\_\_\_\_\_(times per week)
4. Mild/light exercise (minimal effort) (e.g., yoga, archery, fishing from river bank, bowling, golf, walking) \_\_\_\_\_\_\_\_\_\_\_\_\_(times per week)

**Scoring:**

**Answer a) 9 x times per week (the answer “7 times or more” is rated as eight times)**

**Answer b) 5 x times per week (the answer “7 times or more” is rated as eight times)**

**Answer c) 3 x times per week (the answer “7 times or more” is rated as eight times)**

1. Do you smoke?
2. Past-smoker **(1)**
3. Current smoker **(2)**
4. Non-smoker **(0)**

**Alcohol Use Disorders Identification Test-Concise (AUDIT-C)**

1. How often do you have a drink containing alcohol?
2. Never **(0)**
3. Monthly or less **(1)**
4. 2-4 times a month **(2)**
5. 2-3 times a week **(3)**
6. 4 or more times a week **(4)**
7. How many standard drinks containing alcohol do you have on a typical day (one bottle of beer 300 ml, a glass of wine, or a glass of spirit)?
8. 0 **(0)**
9. 1 to 2 **(1)**
10. 3 to 4 **(2)**
11. 5 to 6 **(3)**
12. 7 or more **(4)**
13. How often do you have six or more drinks on one occasion?
14. Daily or almost daily **(4)**
15. Weekly **(3)**
16. Monthly **(2)**
17. Less than monthly **(1)**
18. Never **(0)**

**Eating habits information**

**Starting The Conversation (STC)**

1. Over the past few months, how many times a week did you eat fast food meals or snacks?
2. Less than 1 time **(0)**
3. 1-3 times **(1)**
4. 4 or more times **(2)**
5. Over the past few months, how many servings of fruit did you eat each day?
6. 5 or more **(0)**
7. 3-4 **(1)**
8. 2 or less **(2)**
9. Over the past few months, how many servings of vegetables did you eat each day?
10. 5 or more **(0)**
11. 3-4 **(1)**
12. 2 or less **(2)**
13. Over the past few months, how many regular sodas, juices, or other sugary beverages did you drink each day?
14. Less than 1 **(0)**
15. 1-2 **(1)**
16. 3 or more **(2)**
17. Over the past few months, how many times a week did you eat beans, nuts, chicken, or fish?
18. 3 or more times **(2)**
19. 1-2 times **(1)**
20. Less than 1 time **(0)**
21. Over the past few months, how many times a week did you eat regular snack chips or crackers?
22. 1 time or less **(0)**
23. 2-3 times **(1)**
24. 4 or more times **(2)**
25. Over the past few months, how many times a week did you eat desserts and other sweets?
26. 1 time or less **(0)**
27. 2-3 times **(1)**
28. 4 or more times **(2)**
29. Over the past few months, how much butter or meat fat did you use to season or prepare your food?
30. Very little **(0)**
31. Some **(1)**
32. A lot **(2)**

**Healthy Eating Assessment (HEA)**

1. How would you rate your overall habits of eating healthy foods?
2. Poor **(1)**
3. Fair **(2)**
4. Good **(3)**
5. Very Good **(4)**
6. Excellent **(5)**

**Disinhibition sub-scale from the mindful eating questionnaire (MEQd)**

1. I stop eating when I’m full even when eating something I love
2. Never/Rarely **(4)**
3. Sometimes **(3)**
4. Often **(2)**
5. Usually/Always **(1)**
6. When a restaurant portion is too large, I stop eating when I’m full.
7. Never/Rarely **(4)**
8. Sometimes **(3)**
9. Often **(2)**
10. Usually/Always **(1)**
11. When I eat at “all you can eat” buffets, I tend to overeat.
12. Never/Rarely **(1)**
13. Sometimes **(2)**
14. Often **(3)**
15. Usually/Always **(4)**
16. If there are leftovers that I like, I take a second helping even though I’m full.
17. Never/Rarely **(1)**
18. Sometimes **(2)**
19. Often **(3)**
20. Usually/Always **(4)**
21. If there’s good food at a party, I’ll continue eating even after I’m full.
22. Never/Rarely **(1)**
23. Sometimes **(2)**
24. Often **(3)**
25. Usually/Always **(4)**
26. When I’m eating one of my favorite foods, I don’t recognize when I’ve had enough.
27. Never/Rarely **(1)**
28. Sometimes **(2)**
29. Often **(3)**
30. Usually/Always **(4)**
31. When I’m at a restaurant, I can tell when the portion I’ve been served is too large for me.
32. Never/Rarely **(4)**
33. Sometimes **(3)**
34. Often **(2)**
35. Usually/Always **(1)**
36. If it doesn’t cost much more, I get the larger size food or drink regardless of how hungry I feel.
37. Never/Rarely **(1)**
38. Sometimes **(2)**
39. Often **(3)**
40. Usually/Always **(4)**

**Current health status information**

1. Do you have high blood sugar? Yes **(2)** No **(0)** I don’t know **(1)**
2. Do you have elevated blood fats (cholesterol, triglycerides)? Yes **(2)** No **(0)** I don’t know **(1)**
3. Do you have high blood pressure? Yes **(2)** No **(0)** I don’t know **(1)**
4. Do you suffer from any heart disease (heart rhythm disorders, angina pectoris, heart attack)? Yes **(3)** No **(0)**
5. Do you have sleep-disordered breathing (snoring, apnea) and / or increased daytime sleepiness? Yes **(1)** No **(0)**
6. Do you have problems with liver function? Yes **(2)** No **(0)**
7. Do you have problems with kidney function? Yes **(2)** No **(0)**
8. Do you have problems with thyroid function? Yes **(2)** No **(0)**
9. Do you have stomach problems (heartburn, gastritis, stomach ulcer)? Yes **(2)** No **(0)**
10. Do you have problems with stool regulation (constipation, diarrhea, etc.)? Yes **(1)** No **(0)**
11. Do you have skin problems (dermatitis, psoriasis, acne, etc.)? Yes **(1)** No **(0)**
12. Do you have osteoporosis? Yes **(2)** No **(0)**
13. Do you have mental health problems (feeling depressed and/or anxious)? Yes **(2)** No **(0)**
14. Have you been diagnosed with cancer? Yes **(3)** No **(0)**
15. What type of cancer have you been diagnosed with (skip if your answer on previous question is NO)? \_\_\_\_\_\_\_\_\_\_\_\_
16. How would you rate your health-related quality of life on a scale of 1-10? \_\_\_\_\_\_\_\_\_\_\_\_\_rate.

**Scoring:**

**Answer 10-9 (0 points)**

**Answer 8-7 (1 point)**

**Answer 6-5 (2 points)**

**Answer 4-3 (3 points)**

**Answer 2-1 (4 points)**

1. List the medications you are currently taking \_\_\_\_\_\_\_\_\_\_\_\_\_