Central Iowa Psychological Services

Compassionate, Whole Person Care, Where You Matter

Gastric Bypass Pre-Surgical Psychological Evaluation Intake Form

Please complete the following history form in addition to the regular intake form and bring it to your first appointment with us. This is a critical part of your evaluation.

PERSONAL DATA:

Name ____________________ Date ____________________

Address ____________________ Age ______ DOB ______/______/______ Sex M F

____________________ Home Phone (_____) ____________ Leave Messages Y/N?

____________________ Cell Phone (_____) ____________ Leave Messages Y/N?

Email ____________________ Work Phone (_____) ____________ Leave Messages Y/N?

No. Years Education ______ Degree ____________ Occupation ____________________

Marital Status ____________ Currently Living With ____________________

Spouse/Partner's Occupation ____________ No. of Children ________ Ages ____________

Spirituality/Religious Affiliation ____________ Military Service? □ No □ Yes → □Past □ Current

Emergency Contact: Name ____________________ Phone (________) ____________________

Contact Address:____

MAIN CONCERNS: Please list the major reasons that you are seeking gastric bypass surgery, and rate the importance of each reason, according to the scale below:

1 --------2-------- 3 --------4-------- 5 --------6-------- 7 --------8-------- 9 --------10

Not Important Extremely Important RATING

1. ____ ____________

2. ____ ____________

3. ____ ____________

How long have you been considering bariatric surgery? ____________________

Have you done any research regarding bariatric surgery? Yes No

If yes, where did you get your information? ____________________

____

Do you know anyone who has had bariatric surgery? Yes No Who? ____________________

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Health Care Providers: (PLEASE COMPLETE)

Specialty	Name	Address	Phone & Fax Numbers
Primary Care (PCP)			
Gynecologist			
Orthopedic			
Endocrinologist			
Psychologist or Therapist			
Psychiatrist			
Chiropractor			
Other (Please specify)			

Have you had any operations? If yes, please list:

Type of operation Reason for Operation Date of Operation

______________________ ______________________________ ______________________

______________________ ______________________________ ______________________

Have you had any major injuries, accidents, or broken bones? Yes No If yes, please describe below:

____

____

Have you ever been hospitalized for anything other than an operation or medical procedure? Yes No

If so, please list below.

Reason for Hospitalization Dates of Hospitalization

_____________________________________ ______________________

_____________________________________ ______________________

Please list your medications, both prescribed and over the counter medications (including vitamins & inhalers)

Medication Name	Dose (Amount Taken)	Frequency Taken

Please list any allergies or adverse reactions you have to medications:

Medication Name	Reaction You Have/Have Had

WEIGHT HISTORY

Height: _______________ Current weight: _________ Approx. weight at age 18: ________

Lowest weight after age 25: ______________________What is the most you have ever weighed? _________________

Is anyone in your family overweight_______________________Who____

What have they tried to lose weight and has it been successful?____

Is anyone in your family underweight______________________ Who____

DIETING HISTORY

Age you first started dieting: __________. Please fill out the table below about weight loss programs you have tried:

Program	Yes	No	Date(s)	Duration	Weight Lost	Did you consult with a health provider?
Jenny Craig						
Nutri-systems						
Weight watchers						
Opti-fast Medi Fast						
O.A. or TOPS						
Fen/Phen Redux						
Meridia						
Xenical						
Over the counter diet aids						
Atkins Diet						
South Beach Diet						
Other (please specify):						
Other (please specify):						

What was the most successful weight loss that you have achieved and how did you do it? ______________________________

____

____

What behaviors did you learn from dieting that you still use today? ____

____

____

NUTRITION AND FOOD HISTORY

Which do you eat regularly?

□ Breakfast □ Mid-morning snack □ Lunch □ Mid-afternoon snack □ Dinner □ After dinner snack

On average, how often do you eat out each week? ________________________ Times

On average, what size portions do you normally have?

□ Small □ Moderate □ Large □ Extra large □ Uncertain

On average, how often do you eat more than one serving? □ Always □ Usually □ Sometimes □ Never

On average, how long does it usually take you to eat a meal? ____

On average, do you eat while doing other activities (e.g., watching tv, reading, listening to music, etc.)? Yes No

When you snack, which of the following do you usually eat? (Circle all that apply)

Cookies and cake	Candy	Soda/Diet soda
Granola or grain bars	Pastries	Potato chips
Pretzels	Peanuts/mixed nuts	Ice cream
Cheese/crackers	Donuts	Milk, yogurt, dairy products
Fruit	Vegetables	Other:

How often do you eat dessert? _______________ Times per day _______________ Times per week

What do you eat for dessert most often? ____

How many times per week do you eat fried foods? _________________________________

Can you stop eating tempting foods (i.e., cookies, cake, chips, etc.) once you start? □ Yes □ No

Do you get up during the night to eat? □ Yes □ No

Do you have a pattern of overeating and then regretting this behavior? □ Yes □ No

<u>During the past year</u>:

(Circle the response that best answers each question)

How often have you eaten an unusually large amount of food (an amount most people would agree is unusually large) in a short period of time (e.g., during a 2 hour period)?	Never	Less than once per week	Once per week	2-5 times per week	More than 5 times per week
How often have you eaten an unusually large amount of food and felt you could not stop eating or control how much you ate?	Never	Less than once per week	Once per week	2-5 times per week	More than 5 times per week
How often have you eaten unusually large amounts of food in a short time and felt that your eating was out of control?	Never	Less than once per week	Once per week	2-5 times per week	More than 5 times per week

How upset were you about the episodes where you ate unusually large amounts of food?	Not at all	A little	Somewhat	Very much	Extremely
How often have you made yourself vomit or tried other methods of avoiding weight gain (e.g., laxatives, diuretics, excessive exercise) after eating unusually large amounts of food?	Never	Less than once per week	Once per week	2-5 times per week	More than 5 times per week

EXERCISE STATUS

How often do you get cardiovascular exercise for at least 20-30 minutes per session?

□ No regular program □ 1 time/week □ 2 times/week □ 3-4 times/week □ 5 + times/week

Please circle the number below that describes how active you are in a typical day:

Very sedentary **Very active**
1--------------------------2--------------------------3--------------------------4--------------------------5

Briefly describe your exercise program:

____

____

Is your occupation?
□ Inactive/sedentary □ Light work (e.g., cleaning, light carpentry) □ Moderate work □ Heavy work (e.g., heavy carpentry, lifting)

EXERCISE PREFERENCES

How much time are you willing to devote to an exercise program? Minutes per session? ________________

Days per week? ____________________

Which of the following activities would you be willing to do regularly? Circle all that apply.

Aerobics	Dancing	Jogging/running	Rowing	Tennis
Active gardening	Downhill skiing	Martial arts	Skating	Volleyball
Backpacking	Football	Mountain climbing	Soccer	Walking
Baseball/softball	Golfing	Racquetball/handball	Stair/bench stepping	Weight training
Bicycling	Hiking	Rollerblading	Stretching	Yoga
Cross country skiing	Hockey	Rope skipping	Swimming	Other:

GOALS FOR BARIATRIC SURGERY

What are your goals related to the surgery? ____

____

____

What is your greatest fear regarding the surgery?____

____

____

What is your greatest hope regarding the surgery? ____

____

____

Which of the following people do you expect to support your efforts to lose weight following your surgery?

□ Spouse	□ Sibling(s)	□ Friends	□ Members of your church
□ Children	□ Parent(s)	□ Coworkers	□ Other (please specify)

Which of the following people do you expect to oppose or undermine your efforts to lose weight following your surgery?

□ Spouse	□ Sibling(s)	□ Friends	□ Members of your church
□ Children	□ Parent(s)	□ Coworkers	□ Other (please specify)