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BARIATRIC INTAKE FORM

(you may write in the notes section on each page, or attach additional sheets if more space is needed)

Name: _____ Date of Birth: _____
Name of Bariatric Program: _____
Name of surgeon: _____
Is this your first evaluation for bariatric surgery? ___yes ___no
If no, please provide the name of the previous bariatric program/surgeon and date of assessment: _____
Which surgery are you being evaluated for?
___ lap band ___Roux-en-Y ____ gastric sleeve ___duodenal switch ___
other:_____
Have you begun working with the program's dietician? ___ no ___ yes
If yes, what changes does the dietician have you working on?
_____
Have you been given a pre-surgery weight loss goal? ___no ____ yes

Height: _____ Current weight: _____ Highest weight in the past _____
Post-surgery weight loss goal: _____
How long have you had problems with being overweight? _____
Do you have close relatives (parents, siblings, grandparents) who are significantly overweight?
___no ____yes. If yes, please list them (no names, just "mother")
_____
Over the years. is there anything has brought on weight gain, or has made it worse?
_____

Please list all medical problems that you have, in addition to excessive weight:
_____
_____
Please list all your current mediations (or attach a list):
_____
_____
_____
Is your primary medical provider supportive of you having bariatric surgery? ___ yes ___no. If no, what is your understanding of why the medical provider is concerned about you having bariatric surgery? _____

(notes)

BARIATRIC INTAKE FORM
PAGE 2

How often do you currently drink carbonated and caffeinated beverages:
_____
Do you currently smoke or otherwise use nicotine products? ___no ____ yes

Do you currently have problems with eating too much high calorie foods? __ no __ yes
Do you currently have a problem with excessive portions? ___ no ___ yes
If yes to the last two questions, please provide more specific info: _____
_____
Have you ever done any of the following to try to lose weight?
_____ made yourself vomit
_____used laxatives or diuretics
____ starved yourself
Do you have any of the following patterns?
____ grazing (eating small amounts of food throughout the day)
____ lack of satiation (not feeling satisfied after eating a nutritious meal)
____ snacking after your evening meal
____ night eating (getting up during the night to eat)

Please briefly list all of the weight loss programs that you have tried, and results:
_____
_____
_____
_____
_____
_____
_____
_____
How often do you exercise, what do you do, and for how long do you do the activity?
_____
_____

What is your theory about why you have not been able to succeed at weight loss?
_____
_____
_____

(notes)

BARIATRIC INTAKE FORM
PAGE 3

Are you currently seeing a psychiatrist, psychologist, counselor or other mental health professional, or in a mental health program? ___ no ___ yes
If yes, please provide the name(s): _____
If so, please provide current psychiatric (including for anxiety, depression and ADHD) medications:_____
_____

Have you seen a therapist in the past? ___no ___ yes
Have you been prescribed mental health medication in the past? ___ no ___ yes
Have you been in a mental health hospital program in the past? ___ no ___ yes

Have you ever had problems with hallucinations or losing touch with reality?
___ no ___ yes
Have you ever attempted suicide? ___ no ___ yes
Do you have any <u>current</u> concerns about:

- Memory and concentration: ___no ___ yes
- Depression: ___ no ___ yes
- Anxiety: ___ no ___ yes

If yes to any of the last 3 questions, please provide some info about what concerns you:
_____
_____
Please list any other mental health problems or concerns that you have: _____
_____

Do you <u>currently</u> use alcohol? ___no ___ yes
If yes, please list your average <u>number</u> of drinks:
____ per day ____ per week ____ per month ____ per year
Do you use marijuana: ___ yes ___ no If yes, how often: _____
Have you been in a chemical dependency program? ___no ___ yes
Do you have any concerns about whether mental health problems or use of alcohol or drugs will interfere with your ability to follow the aftercare program for bariatric surgery?
___no ___ yes
If yes, please briefly describe your concerns:
_____
_____

(notes)

BARIATRIC INTAKE FORM
PAGE 4

Are you currently prescribed pain medication? ___ no ___ yes
Please describe your experience with pain medication:
___I have never been prescribed
___I was able to manage my pain by taking less than prescribed
___I was able to manage my pain by taking the medication a prescribed
___I had difficulty managing my pain with the prescribed medication

Do you have any close relatives who have mental health problems? ___no ___ yes
If yes, please list them (no names, just relationship to you) and their diagnosis, if known:
_____
_____
Do you have any close relatives who have problems with alcohol or drugs?
___no ___ yes
If yes, please list them (no names, just relationship to you) and a brief description of their problem:_____
_____

How would you describe your sleep?
____ I feel rested when I get up
____ I do not feel rested when I get up
____ I have a problem falling asleep
____ I have a problem staying asleep
If you have a sleep problem, how often, on the average, is this a problem for you?
____ most nights
____ a few nights per week
____ a few nights per month

How would you describe your energy in the average day? _____

How many hours of TV do you watch (sitting and watching, not just TV in the background) in the average day? ___ less than two hours ___ 2 to 4 hours ____ more than 4 hours

Do you <u>currently</u> have any of the following?
Legal charges/court proceedings: ____ no ___ yes
Problem/excessive gambling: ___ no ___ yes
Excessive spending (so that you are stressed by credit problems): ___no ___ yes
If yes to any of the last 3 questions, please provide a brief description:
_____
_____

(notes)

BARIATRIC INTAKE FORM
PAGE 5

Your ethnic background: ___ Caucasian ____ African American ____Hispanic
____Native American ____mixed background ___ other: _____
___ prefer to not be identified in one of these categories

How far did you go in school? ___ high school ___ trade school ___ college
___ graduate school
Are you currently working? ___ yes ___ no
If yes, what is your job? _____
If yes, are you satisfied with this job? ___yes ___ no
If not working, how do you support yourself financially? _____

What is your relationship status? ___ single ___ married ___ dating ___ in a long-term relationship
If in a relationship, is your partner supportive of you having bariatric surgery?
___ yes ___ no
If you need support after having surgery, who will you turn to? _____
Are you able to work out relationship conflicts to your satisfaction? __ Yes __ No
If no, please describe your concern: _____
_____
Do you know anyone who has had bariatric surgery: ___ no ___ yes
If yes, please list them (by relationship, such as "friend" or "coworker") and their outcome:_____
_____

Do you have any concerns about meeting any of the pre-surgery expectations that your bariatric program has for you?
___ No, I feel that I am on track for being cleared for surgery
____ Yes – please describe your concerns: _____
_____
Are you anxious about having surgery? ___ no ___ yes
If yes, please explain your concern: _____

THANK YOU FOR PROVIDING ALL THIS VERY HELPFUL INFORMATION!
We will discuss this information during the interview, and you will be able to provide any additional information that will be helpful.
Sincerely,
Richard Sethre, PsyD, LP

(notes)