



# 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? <input type="checkbox"/> No <input type="checkbox"/> Yes → <input type="checkbox"/> Past <input type="checkbox"/> Current
<u>Emergency Contact:</u> 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? \_\_\_\_\_

**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

**During the past year:**

(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



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?

- |                                   |                                     |                                    |   |
|-----------------------------------|-------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Spouse   | <input type="checkbox"/> Sibling(s) | <input type="checkbox"/> Friends   | <input type="checkbox"/> Members of your church |
| <input type="checkbox"/> Children | <input type="checkbox"/> Parent(s)  | <input type="checkbox"/> Coworkers | <input type="checkbox"/> Other (please specify) |

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

- |                                   |                                     |                                    |   |
|-----------------------------------|-------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Spouse   | <input type="checkbox"/> Sibling(s) | <input type="checkbox"/> Friends   | <input type="checkbox"/> Members of your church |
| <input type="checkbox"/> Children | <input type="checkbox"/> Parent(s)  | <input type="checkbox"/> Coworkers | <input type="checkbox"/> Other (please specify) |