

Psychological Questionnaire

Please complete this questionnaire and bring it with you to your first appointment.

Name: _____ Date: _____

Date of Birth: _____ Surgeon: _____

I am interested in: Gastric Bypass Gastric Sleeve Conversion Unsure

Personal Information

Marital Status: Single Married Live-in partner Dating someone
 Remarried Widowed Divorced Separated

Children (include ages): _____

Who do currently live with? _____

Are you sexually active? **Yes No**

Are you planning to become pregnant within the next two years? **Yes No**

Do you use contraception? **Yes No** If Yes, what method: _____

Work status: Employed Unemployed Disabled Self-employed Homemaker Other: _____

List last three places of employment:

1. _____ # of years _____
2. _____ # of years _____
3. _____ # of years _____

Current Financial/Legal Status (check all that apply)

- I have some savings available
- I live paycheck to paycheck, no savings
- I have filed bankruptcy or used credit counseling
- I have been arrested within the last 5 years
- I am currently involved in a legal action

Weight and Eating Patterns

When did you begin to put on weight?

- Childhood Adolescence Early Adulthood Adulthood After pregnancy/children
- After a significant event in my life

Which statement best describes your weight gain?

- Slow and Steady over several years
- Gained most of my excess weight in less than 12 months
- I've been this big all of my adult life

What is the most amount of weight you have ever lost? _____

How long were you able to maintain this weight loss? _____

Check the habits below that best describe your eating style when you are NOT "dieting":

- | | | |
|---|--|---|
| <input type="checkbox"/> Meal skipping | <input type="checkbox"/> Large portions | <input type="checkbox"/> Grazing |
| <input type="checkbox"/> Mindless eating | <input type="checkbox"/> Binge eating | <input type="checkbox"/> Emotional eating |
| <input type="checkbox"/> Snacking on sweets | <input type="checkbox"/> Hiding food | <input type="checkbox"/> Fast food |
| <input type="checkbox"/> Snacking on crunchy food | <input type="checkbox"/> Drinking soda | <input type="checkbox"/> Restaurants |
| <input type="checkbox"/> Snacking on salty food | <input type="checkbox"/> High calorie drinks | |

- | | | |
|---|------------|-----------|
| Do you eat much more rapidly than normal? | Yes | No |
| Do you eat until feeling uncomfortably full? | Yes | No |
| Do you eat large amounts of food when not feeling physically hungry? | Yes | No |
| Do you eat alone because of feeling embarrassed by how much you eat? | Yes | No |
| Do you feel disgusted, depressed, or very guilty after eating? | Yes | No |
| When you eat, do you feel that you are in control? | Yes | No |
| Do you drink caffeinated beverages (e.g., coffee, soda, energy drinks)? | Yes | No |
| Do you drink carbonated beverages (e.g., soda, beer, sparkling water)? | Yes | No |

Check the types of movement and physical activity you are most interested in doing:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Housework, yard work | <input type="checkbox"/> Leisure walking | <input type="checkbox"/> Jogging, running | <input type="checkbox"/> Softball, football |
| <input type="checkbox"/> Weight, resistance training | <input type="checkbox"/> Yoga | <input type="checkbox"/> Dancing | <input type="checkbox"/> Other: _____ |

Attitude Toward Surgery

What do you think are the possible side effects or complications of the surgery? _____

How do your family, friends, loved ones feel about your having the surgery? _____

What arrangements have you made for recovery after surgery (i.e., child care, meal preparation, time off from work)? _____

Do you have long-term or short-term disability insurance? **Yes** **No**

How much time do you plan on taking to recover? _____

Current Life Stressors (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> No significant stressors | <input type="checkbox"/> Marital reconciliation | <input type="checkbox"/> Career change |
| <input type="checkbox"/> Death of spouse | <input type="checkbox"/> Personal injury or illness | <input type="checkbox"/> Mortgage foreclosure |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Death of a close family member | <input type="checkbox"/> Change in living conditions |
| <input type="checkbox"/> Jail/legal issues | <input type="checkbox"/> Increased marital arguments | <input type="checkbox"/> Fertility treatments |
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Addition to family | <input type="checkbox"/> Change in work hours and/or conditions |
| <input type="checkbox"/> Fired from job | <input type="checkbox"/> Change in financial status | <input type="checkbox"/> Change in family member's health |
| <input type="checkbox"/> Retirement | <input type="checkbox"/> Death of a close friend | <input type="checkbox"/> Bankruptcy/credit counseling |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Financial debt | <input type="checkbox"/> Son or daughter leaving home |
| <input type="checkbox"/> Marital separation | <input type="checkbox"/> Layoff/reorganization at work | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Break-up | <input type="checkbox"/> Other: _____ | |

Have you ever seen things that other people did not see? **Yes No**

If yes, describe the situation: _____

Have you ever heard voices when no one was around? **Yes No**

If yes, describe the situation: _____

Have you ever had a belief or idea that your family or friends never understood? **Yes No**

If yes, describe the situation: _____

Previous Mental Health Treatment

Have you ever participated in counseling or psychotherapy? **Yes No**

If yes, provide treatment provider(s) name(s)/location(s): _____

Did you find this treatment effective? **Yes No**

Have you ever been hospitalized for depression, anxiety or other mental illness? **Yes No**

If yes, provide treatment facility name(s)/location(s): _____

Did you find this treatment effective? **Yes No**

Have you ever been prescribed antidepressant, anti-anxiety, or other psychiatric medication? **Yes No**

If yes, provide treatment provider(s) name(s)/location(s): _____

Did you find this treatment effective? **Yes No**

Current psychiatric medications: _____

Alcohol and Substance Use

Do you drink alcohol? **Yes No**

If yes, what do you drink? _____

How many drinks per week? _____

Have you ever felt you should cut down on your drinking? **Yes No**

Have people annoyed you by criticizing your drinking? **Yes No**

Have you felt bad or guilty about your drinking? **Yes No**

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? **Yes No**

Check all substances that you have used:

- | | |
|---|---|
| <input type="checkbox"/> Marijuana, hashish | <input type="checkbox"/> Sedatives (e.g., valium, Quaalude) |
| <input type="checkbox"/> Narcotics (e.g., heroin, morphine, opium) | <input type="checkbox"/> Hallucinogens (e.g., LSD, Mescaline) |
| <input type="checkbox"/> Stimulants (e.g., speed, Ecstasy, Molly, meth) | <input type="checkbox"/> Solvents (e.g., glue) |
| <input type="checkbox"/> Cocaine, Crack | <input type="checkbox"/> Bath Salts |

Symptoms Surveys

Read each item in the list below. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not at all	Mildly It didn't bother me much.	Moderately It wasn't pleasant at times.	Severely It bothered me a lot.
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding/racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky / unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot/cold sweats	0	1	2	3
Column Sum				

Please read the entire group of statements in each box. Then pick out the ONE statement in that group that best describes the way you have been feeling in the past TWO weeks, including today. Put a check beside the statement you have chosen. If several statements in the group apply, choose the statement with the highest number for that group. DO NOT choose more than ONE statement for any group.

<p>__ 0 I do not feel sad. __ 1 I feel sad. __ 2 I am sad all the time and I can't snap out of it. __ 3 I am so sad and unhappy that I can't stand it</p>	<p>__ 0 I am no more irritated by things than I ever was. __ 1 I am slightly more irritated now than usual. __ 2 I am quite annoyed or irritated a good deal of the time. __ 3 I feel irritated all the time.</p>
<p>__ 0 I have not lost interest in other people. __ 1 I am less interested in other people than I used to be. __ 2 I have lost most of my interest in other people. __ 3 I have lost all of my interest in other people.</p>	<p>__ 0 I make decisions about as well as I ever could. __ 1 I put off making decisions more than I used to. __ 2 I have greater difficulty in making decisions more than I used to. __ 3 I can't make decisions at all anymore.</p>
<p>__ 0 I am not particularly discouraged about the future. __ 1 I feel discouraged about the future. __ 2 I feel I have nothing to look forward to. __ 3 I feel the future is hopeless and that things cannot improve.</p>	<p>__ 0 I do not feel like a failure. __ 1 I feel I have failed more than the average person. __ 2 As I look back on my life, all I can see is a lot of failures. __ 3 I feel I am a complete failure as a person.</p>
<p>__ 0 I get as much satisfaction out of things as I used to. __ 1 I don't enjoy things the way I used to. __ 2 I don't get real satisfaction out of anything anymore. __ 3 I am dissatisfied or bored with everything.</p>	<p>__ 0 I don't feel that I look any worse than I used to. __ 1 I am worried that I am looking old or unattractive. __ 2 I feel there are permanent changes in my appearance that make me look unattractive __ 3 I believe that I look ugly.</p>
<p>__ 0 I don't feel particularly guilty. __ 1 I feel guilty a good part of the time. __ 2 I feel quite guilty most of the time. __ 3 I feel guilty all of the time.</p>	<p>__ 0 I can work about as well as before. __ 1 It takes an extra effort to get started at doing something. __ 2 I have to push myself very hard to do anything. __ 3 I can't do any work at all.</p>
<p>__ 0 I don't feel disappointed in myself. __ 1 I am disappointed in myself. __ 2 I am disgusted with myself. __ 3 I hate myself.</p>	<p>__ 0 I don't get more tired than usual. __ 1 I get tired more easily than I used to. __ 2 I get tired from doing almost anything. __ 3 I am too tired to do anything.</p>
<p>__ 0 I don't feel I am any worse than anybody else. __ 1 I am critical of myself for my weaknesses or mistakes. __ 2 I blame myself all the time for my faults. __ 3 I blame myself for everything bad that happens.</p>	<p>__ 0 My appetite is no worse than usual. __ 1 My appetite is not as good as it used to be. __ 2 My appetite is much worse now. __ 3 I have no appetite at all anymore.</p>

<p>__0 I don't have any thoughts of killing myself. __1 I have thoughts of killing myself, but I would not carry them out. __2 I would like to kill myself. __3 I would kill myself if I had the chance</p>	<p>__0 I haven't lost much weight, if any, lately. __1 I have lost more than five pounds. __2 I have lost more than ten pounds. __3 I have lost more than fifteen pounds.</p>
<p>__0 I don't cry any more than usual. __1 I cry more now than I used to. __2 I cry all the time now. __3 I used to be able to cry, but now I can't cry even though I want to.</p>	<p>__0 I am no more worried about my health than usual. __1 I am worried about physical problems like aches, pains, upset stomach, or constipation. __2 I am very worried about physical problems and it's hard to think of much else. __3 I am so worried about my physical problems that I cannot think of anything else.</p>
	<p>__0 I have not noticed any recent change in my interest in sex. __1 I am less interested in sex than I used to be. __2 I have almost no interest in sex. __3 I have lost interest in sex completely.</p>



Reviewed by:
Mental Health Provider's signature _____ **Date:** _____