Etheridge Psychology
Assessment and Psychotherapy

1120 SE Cary Pkwy Suite 201
Cary, NC 27518
tel 919.600.4906
fax 888.887.6361
www.etheridgepsychology.com

PRE-BARIATRIC SURGERY PSYCHOLOGICAL EVALUATION QUESTIONNAIRE

Completing the following questionnaire is optional, but it will give your psychologist valuable information and will likely shorten the duration of your appointment. You may either fax, mail, or bring the questionnaire with you to your appointment.

Name: _____ **DOB:** _____ **Age:** _____

Surgeon: _____ **When do you hope to have surgery?** _____

This questionnaire can provide you with valuable insight into the factors that have contributed to your weight problem and interfered with your ability to lose weight. Use it as a tool for self-reflection!

What type of surgery are you planning to have?

- ☐ Gastric Bypass
- ☐ Gastric Sleeve
- ☐ SIPS
- ☐ Lap Band
- ☐ Duodenal Switch
- ☐ Undecided
- ☐ Revision
- ☐ Other: _____

Have you attended a bariatric surgery seminar? ☐ yes ☐ no

Have you had your pre-op nutritionist visit yet? ☐ yes ☐ no

SOCIAL HISTORY

Where were you born? _____
Where were you raised? _____
Who raised you? _____
Number of sisters: _____
Number of brothers: _____

Overall, was your childhood:

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

Marital Status:

- ☐ Single
- ☐ Married # yrs ___
- ☐ Cohabiting # yrs ___
- ☐ Widowed
- ☐ Divorced # yrs ___

 # children: _____
What are their ages? _____

Education:

- ☐ Less than high school
- ☐ High school diploma or GED
- ☐ Some college
- ☐ AA degree
- ☐ Certification
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Doctorate/other adv degree

Current Occupation:

_____

- ☐ Unemployed How long? _____
- ☐ Retired How long? _____

Who will be taking you home from surgery and caring for you? _____

Has that person been educated about the surgery, aftercare, and how to best be supportive of you? ☐ Yes ☐ No

Do you feel you have enough social support overall in your life right now? ☐ Yes ☐ No

MEDICAL, MENTAL HEALTH, AND SUBSTANCE USE HISTORY

CURRENT MEDICAL PROBLEMS:

☐ Diabetes ☐ Hypertension ☐ High Cholesterol ☐ Sleep Apnea ☐ Arthritis
☐ Joint Pain ☐ Edema (swelling) ☐ Acid Reflux/other GI ☐ PCOS

Please list any other medical problems: _____

WHAT SURGERIES HAVE YOU HAD?

☐ Gallbladder removal ☐ Tonsillectomy ☐ Joint/bone ☐ Caesarian section ☐ Hysterectomy

Please list any other surgeries you have had: _____

Any complications such as infection or delayed healing with any surgery? ☐ Yes ☐ No

Have you ever suffered a head injury, seizure, or losses of consciousness? ☐ Yes ☐ No

CURRENT MEDICATIONS

Name of Medication (brand or generic name is fine)	Strength	Dose	When started

MENTAL HEALTH AND SUBSTANCE USE HISTORY:

Have you ever been in counseling or psychotherapy?	☐ yes	☐ no
Have you ever been admitted to a psychiatric hospital?	☐ yes	☐ no
Have you ever been prescribed an antidepressant medication or any medication for a mental condition, anxiety, nerves, or sleep?	☐ yes	☐ no
If yes, please name the medication(s): _____		
Have you ever been diagnosed with depression, an anxiety disorder, bipolar disorder, ADHD, or any other mental health condition?	☐ yes	☐ no
Have you ever had serious suicidal thoughts or tried to harm yourself?	☐ yes	☐ no
Do you have any family history of mental health problems?	☐ yes	☐ no
How many drinks with alcohol do you have per month on average? _____		
Do you use tobacco?	☐ yes	☐ no
Do you use drugs like marijuana, speed or other street drugs?	☐ yes	☐ no
Have you ever abused a prescription medication?	☐ yes	☐ no
Have you ever, in the past, had a problem with alcohol, drugs, or prescription medication?	☐ yes	☐ no
Do you have a family history of drug or alcohol abuse?	☐ yes	☐ no

WEIGHT HISTORY

Current Height:	_____	Weight at age 18:	_____	Overweight since (age):	_____
Current Weight:	_____	Weight at age 30:	_____	Family history of obesity?	☐ yes ☐ no
Highest Weight:	_____	Weight at age 40:	_____	What is your goal weight?	_____

What kind of diet did you eat as a CHILD? Please check all that apply.

☐ Well-balanced but high in fat/calories (e.g. southern foods)
☐ Freq. convenience foods (e.g. mac & cheese, TV dinners)
☐ Frequently ate "junk" foods such as candy, chips, soda
☐ Healthy, well-balanced, did not overeat
☐ Frequently ate at restaurants
☐ Frequently ate fast food

As a CHILD, were you:

☐ Required to clean your plate?
☐ Bribed/rewarded with sweets?
☐ Comforted with food when you were sad or hurt?
☐ Punished by withholding food?
☐ Punished for not eating?
☐ Teased or shamed because of your weight?

What factors do you think have contributed to your weight problem as an ADULT?
Please check all that apply.

☐ Portions too large
☐ Eating at night
☐ Restaurant eating
☐ Eating fast food
☐ Sweet tooth
☐ Medication side effects
☐ Not enough activity
☐ Genetic factors
☐ Poor metabolism
☐ Grazing/snacking
☐ Eating a diet too high in fat and calories
☐ Regular soda, sweet tea, other sugary drinks
☐ Skipping meals and then overeating later
☐ Family gatherings center around food
☐ I am not sure why I became overweight

Please list any other factors that have contributed to your weight problem as an ADULT:

_____

Have you EVER engaged in any of the following behaviors?

Significant overeating during which you felt out of control and could not stop eating	☐ yes	☐ no
Vomiting purposefully after eating in an attempt to rid yourself of calories	☐ yes	☐ no
Abusing laxatives or diuretics for the purpose of weight loss	☐ yes	☐ no
Starving yourself for the purpose of weight loss	☐ yes	☐ no

If you have tried any of the following weight loss methods, please indicate when you tried them, how long you stayed on them, and how much weight you lost.

Diets you've tried:	Year(s)	How long?	pounds lost	Medication/ Supplement Tried:	Year(s)	How long?	pounds lost
Atkins				Alli			
Cabbage soup diet				B-12 shots			
Calorie counting				Dexatrim			
Fasting				Ephedra			
Grapefruit diet				HCG			
Jenny Craig				Hydroxycut			
LA Weight Loss				Meridia			
Nutri System				Phen-fen			
Physician supervised				Phentermine/Adipex			
Slim Fast				Redux			
South Beach				Xenical			
Weight Watchers							

Please list any other dieting methods tried:

Please list any other weight loss medications:

Why do you suppose you have been unsuccessful losing weight permanently?

Please check all that apply:

☐ I was too hungry on diets to keep it up forever
☐ I could no longer afford the diet I was on
☐ I did not exercise enough
☐ I could not exercise enough due to pain
☐ I lost my motivation
☐ I did not have enough support from others
☐ My busy life got in the way of weight loss efforts
☐ I honestly have no idea

Please list any other reasons you think you have been unable to lose weight permanently:

_____ _____

_____ _____

How will bariatric surgery help you when other methods of weight loss have not helped?

_____

PHYSICAL ACTIVITY

Please refer to this key when answering the items about your history of physical activity:

Very active: Average of an hour of intense physical activity per day. ex. Lots of outdoor play, regular intense gym workouts, very frequent physically demanding leisure activities such as hiking, swimming, running.

Moderately active: Exercise ~3-5x a week with moderate activity such as walking. Some physical leisure activities such as golf, hiking, leisurely swimming, gardening. (As a child, played outside some but also watched a lot of television and/or played video games)

Largely inactive: Mostly sedentary leisure activities such as playing cards, crafts, watching television, internet. (As a child, mostly sedentary play activities, TV, video games)

How physically active were you…	Very Active	Moderately Active	Mostly Inactive
As a Child (under 13 years)	☐	☐	☐
As a Teen (13-19)	☐	☐	☐
In your 20s	☐	☐	☐
In your 30s	☐	☐	☐
In your 40s	☐	☐	☐
In your 50s	☐	☐	☐
Over the past three months	☐	☐	☐

What is your exercise plan for after surgery? Activit(ies): _____

How many times a week? For how long each time? _____ minutes

What are your chief barriers to exercise? Check all that apply.

☐ I don't have time
☐ Childcare
☐ Pain/discomfort/fatigue
☐ Resources (e.g. cannot afford gym membership)
☐ Motivation
☐ Other: _____

Thank you for completing this questionnaire. We hope that it has gotten you thinking about some of the behavioral factors involved in weight gain, weight loss, and success after bariatric surgery. We will discuss some of these in more detail at your appointment. We look forward to meeting you!