PATHWAYS
PSYCHOLOGY, PLLC
Cristin M. Saffo, Psy.D.

www.pathwayspsych.net
2971 Crouse Lane, Suite A
Burlington, NC 27215
Office: (336) 524-1628
Fax: (336) 792-5896

QUESTIONNAIRE FOR PRE-BARIATRIC SURGERY EVALUATION

This questionnaire is designed to help me gather information for your upcoming evaluation. By responding to these questions as thoroughly as you can, you will be:

- Providing me with relevant background information.
- Helping me to get to know you in a more efficient and effective way.
- Reducing the amount of time we will need to spend reviewing basic information during your evaluation.

Some items on this questionnaire may not pertain to you- please feel free to skip those. If you need additional space to answer any of the questions, please use the back of the page. If there is a question you do not wish to answer in writing, please leave it blank and we can discuss it together during your evaluation.

This questionnaire, and your responses (whether verbal or in writing), will become part of your clinical file and will be kept confidential.

Name _____ DOB _____

Occupation/Year in School _____

Employer/School _____

Current Household

Please list current household members (if you live at school, please list family at home):
(continue on back if needed)

Name	Age	Relationship to you	Occupation

Family Members

Please list the members of the family with whom you were raised (parents/caregivers, siblings, etc.)
(continue on back if needed)

Name	Age	Relationship to you	Occupation

Do you have any children, stepchildren, or other close family members who do not live with you?
Y _____ N _____
If yes, please list below: (continue on back if needed)

Name	Age	Relationship to you	Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Academic and Work History

Please list the last completed grade/degree(s) in school: _____

Are you currently in school or training? Y _____ N _____ If yes, please describe:

_____

Please provide a brief summary of your school and work history:

_____

_____

_____

_____

_____

Psychological History

Have you received mental health treatment in the past? If so, please provide a brief summary:

_____

_____

_____

_____

Are you currently taking any psychiatric medications? Y _____ N _____
If yes, please list below:

Medication	Dosage	Prescribing Doctor	Reason for Medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you had any psychiatric hospitalizations? Y _____ N _____
If yes, please list below (dates can be approximate; use back if needed):

Date(s)	Hospital	Reason for Hospitalization
_____	_____	_____
_____	_____	_____

Is there a family history of any mental health issues or treatment (including depression, anxiety, mania, hallucinations, psychosis, suicide, or any other emotional disturbance)? If so, please describe: (do not include addictive behaviors here, they are addressed later)

_____

_____

_____

_____

Medical History

Have you had a physical exam within the last year? Y _____ N _____

Do you have any current medical concerns (diabetes, arthritis or joint pain, acid reflux/GI problems, thyroid, high blood pressure, high cholesterol, sleep apnea)? If so, please describe (use back if needed):

_____

_____

_____

_____

_____

Are you currently taking any medications for medical (non-psychiatric) reasons? Y _____ N _____
If yes, please list below (use back if needed):

Medication	Dosage	Prescribing Doctor	Reason for Medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any drug allergies? Y _____ N _____ If yes, please describe:

_____

Have you had any medical hospitalizations or surgeries? Y _____ N _____
If yes, please list below (dates can be approximate; use back if needed):

Date(s)	Hospital	Reason for Hospitalization
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is there a family history of any major medical and/or hereditary issues (including weight issues, cancer, heart disease, stroke, seizures, diabetes, high blood pressure, high cholesterol)? If so, please describe:

_____

_____

_____

_____

_____

_____

Have you ever smoked cigarettes? Y _____ N _____
Have you ever used any other nicotine or tobacco products? Y _____ N _____
If yes, please describe your history:

_____

_____

Alcohol, Substance Use, and Addiction History

Do you currently drink alcohol? Y _____ N _____ If yes, please describe amount and frequency:

_____

_____

Do you currently use any recreational drugs (including marijuana), or medications not prescribed for you? Y _____ N _____
If yes, please describe amount and frequency:

_____

_____

Have you ever had concerns about your own alcohol or substance use, or any type of addictive behavior (such as gambling, Internet use, etc.)? Have others ever expressed any concern about your behavior in these areas to you? If so, please describe:

_____

_____

_____

_____

Is there any family history of problems with alcohol use, substance use, or addictive behaviors? If so, please describe:

_____

_____

_____

_____

Weight and Eating History

Current height: _____ Current weight: _____

Lowest adult weight: _____ At what age: _____

Highest adult weight: _____ At what age: _____

Overweight since (age): _____ Goal weight: _____

Anticipated time frame for reaching goal weight: _____

Please describe your motivation(s) for having weight loss surgery (use back if needed):

_____

_____

_____

_____

_____

_____

Please indicate if you have tried any of the following weight loss methods:

_____ Atkins diet
_____ cabbage soup diet
_____ calorie counting
_____ fasting
_____ grapefruit diet
_____ Jenny Craig
_____ LA Weight Loss
_____ Nutri System
_____ portion control
_____ Slim Fast
_____ South Beach diet
_____ Weight Watchers
_____ exercise

_____ Alli
_____ B-12 shots
_____ Belviq
_____ Dexatrim
_____ Ephedra
_____ HCG
_____ Hydroxycut
_____ Lipozene
_____ Meridia
_____ Fen phen
_____ Phentermine/Adipex
_____ Redux
_____ Xenical

Please list any other weight loss methods or medications you have tried:

_____

_____

Who shops for and prepares most of your food? _____

_____

Please provide examples of foods eaten during a typical week in the following categories:

Protein (e.g. chicken, turkey, meat, fish) _____

_____

Nuts _____

Beans (e.g. kidney, pinto) _____

Dairy (e.g. milk, eggs, cheese, yogurt) _____

_____

Starches and carbohydrates (e.g. pasta, rice, potatoes, bread) _____

_____

_____

Vegetables _____

_____

Fruit _____

_____

Beverages _____

_____

How often do you eat at restaurants? _____ times per week

How often do you eat take-out? _____ times per week

How often do you eat fast food? _____ times per week

How many meals and snacks do you eat in a typical day? _____

_____

Are your portion sizes typically small, medium, or large? _____

Are there any food(s) that you consider your "weakness(es)", that are hard to resist? _____

_____

Support System/Network

Please list who you will be able to rely on for support both pre- and post-surgery (family, friends, co-workers, church members, support groups, etc.)

_____

_____

_____

_____

_____

_____

Questions and Concerns

Do you have any questions or concerns about your upcoming surgery and/or recovery that you would like to discuss during your evaluation?

_____

_____

_____

_____

_____

_____ _____

Signature Date

Revised January 2019