

**\*\*BRING THIS COMPLETED FORM TO YOUR APPT AT SPECTRA HEALTHCARE\*\***

**PSYCHIATRIC & PSYCHOSOCIAL WORKSHEET**

Name: \_\_\_\_\_ Sex: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Ethnic Origin: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Other) \_\_\_\_\_

**ATTITUDE TOWARD SURGERY**

Please state which surgeon referred you for this evaluation? \_\_\_\_\_

When did you begin to seriously consider gastric bypass surgery? \_\_\_\_\_

Why? \_\_\_\_\_

What is your motivation for having the surgery? \_\_\_\_\_

What research have you done on your own (e.g., internet, interviews)? \_\_\_\_\_

How much weight would you like to lose? \_\_\_\_\_ How much weight would you be satisfied to lose? \_\_\_\_\_

What do you know about the postoperative issues of undergoing a gastric bypass? \_\_\_\_\_

Do you have any reservations about having gastric bypass surgery? YES / NO If yes, describe \_\_\_\_\_

**EATING AND WEIGHT ISSUES**

How was food viewed in your family when you were growing up? \_\_\_\_\_

Was there enough food? \_\_\_\_\_ Were you required to "clean your plate?" \_\_\_\_\_

Did you celebrate occasions with food? \_\_\_\_\_ Were you rewarded with food? \_\_\_\_\_

Is/was your mother overweight? \_\_\_\_\_ Is/was your father overweight? \_\_\_\_\_

List siblings who are overweight? \_\_\_\_\_

Was dieting ever discussed in your household? \_\_\_\_\_

At what age did you begin to believe your weight was a problem? \_\_\_\_\_

What made you think your weight was a problem? \_\_\_\_\_

How old were you when you began dieting? \_\_\_\_\_ Did your parents make you diet? \_\_\_\_\_

Were you teased about your weight when you were young? \_\_\_\_\_

Please list your **most successful** weight loss attempts:

Program followed/method used?	Start Date/ End Date	How much weight did you lose?	How long did you maintain this loss?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please describe your use of diet pills or weight loss medications:

Diet Pill or Medication	Prescribing M.D., if applicable	Frequency and Quantity of Use	Date of Last Use	Duration of Use

Did you ever overuse any of these medications? YES/NO/Not Applicable If yes, explain \_\_\_\_\_

In your own words, describe the reason(s) why you have been unsuccessful in your past weight loss attempts?

Are you currently following a special diet/eating pattern? YES / NO If yes, explain \_\_\_\_\_

Have you ever eaten to comfort yourself or to cope with difficult emotions? YES / NO

How often does this occur?

When was the last occurrence?

Favorite foods for this purpose

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever eaten, in a period of 2 hours or less, a quantity of food definitely larger than what most individuals would eat under similar circumstances? YES / NO

How often does this occur?

When was the last occurrence?

Favorite foods for this purpose

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you regularly consume over 50% of your daily food intake in the evening or at night? YES / NO

Do you feel out of control during these periods of high food intake? YES / NO

Do you ever feel guilty or ashamed after eating? YES / NO

Have you ever intentionally vomited, used laxatives or enemas to get rid of the food you have eaten? YES / NO

How often does this occur?

When was the last occurrence?

Preferred method

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you engaged in fasting or excessive exercise to compensate for a period of high food intake? YES / NO

How often does this occur?

When was the last occurrence?

Preferred method

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you preoccupied with negative self-evaluation regarding your body appearance or weight? YES / NO

If so, when was the onset of this preoccupation? \_\_\_\_\_

### MEDICAL HISTORY

Please list any current or past medical issues including Diabetes, Thyroid, Arthritis, etc. \_\_\_\_\_

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**PERSONAL HISTORY**

Where were you born? \_\_\_\_\_ Where were you raised? \_\_\_\_\_

Did both parents raise you? YES / NO If no, whom? \_\_\_\_\_

Other significant caregivers? \_\_\_\_\_

Describe your childhood in one word or one phrase \_\_\_\_\_

Please list parents and siblings:

Name	Age	Relationship	Occupation	Where do they live?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

When you were growing up, did you witness or survive any significant traumas including physical abuse, sexual abuse, death of a loved one, major injury, natural disaster, etc.? YES / NO Describe \_\_\_\_\_

Have you participated in any mental health treatment as a result of this experience? YES / NO

Dates	Location	Provider	Diagnosis	Issues/Outcomes
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**CURRENT SITUATION**

Please list all members of your household (spouse/partner, children, parents, siblings, etc.):

Name	Age	Relationship	Occupation or Grade in School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you a caregiver for any individual(s) (e.g., elderly parent, family member with special needs)? YES / NO

Describe situation \_\_\_\_\_

Who will be caring for this individual(s) when you have surgery? \_\_\_\_\_

Do you have any other current or recent stressors (traumas, problems with children, illness, etc.)? \_\_\_\_\_

Do you have any legal problems? \_\_\_\_\_

**MARITAL HISTORY**

Current Marital Status (circle): Married / Divorced / Single / Common Law

Marital History: Number of Marriages: \_\_\_\_\_ Duration of Marriage(s): \_\_\_\_\_

Number of Divorces: \_\_\_\_\_ Date(s): \_\_\_\_\_

Briefly Describe Circumstances Leading to Divorce(s): \_\_\_\_\_

Do you consider your **current** marriage a strong one? YES / NO Explain \_\_\_\_\_

Regarding **current** marriage, any past separations/divorces? YES / NO

Describe Circumstances \_\_\_\_\_

Have you ever participated in couple counseling with your **current** spouse? YES / NO

Describe Circumstances \_\_\_\_\_

**PRIMARY SUPPORT PERSON**

Who have you designated as your primary support person? \_\_\_\_\_

What is your relationship with him/her? \_\_\_\_\_

How long have you known him/her? \_\_\_\_\_

Have you ever participated in counseling (e.g., couple or family) with your primary support person? YES / NO

Describe Circumstances \_\_\_\_\_

What is your primary support person's highest level of education? \_\_\_\_\_

Is your primary support person currently employed? YES / NO

If yes, please list occupation and employer? \_\_\_\_\_

Will your primary support person's employer allow him/her time off for your surgery? YES/NO/Not Applicable

Has he/she already talked with his/her supervisor? YES / NO

How much time is your primary support person planning to take off from work? \_\_\_\_\_

Will you need to compensate for lost wages? YES / NO If yes, how \_\_\_\_\_

Describe how you feel about having your primary support person provide all of your physical care after surgery (e.g., toileting, dressing, food preparation). \_\_\_\_\_

**SOCIAL SUPPORT** – Please list any other people who will be able to assist you after the surgery:

Name	Age	Relationship	Occupation	Where do they live?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**EMPLOYMENT HISTORY**

Are you currently employed? YES / NO What is your highest level of education? \_\_\_\_\_

What is your Occupation? \_\_\_\_\_ Who is your employer? \_\_\_\_\_

Will your work allow you time off for the surgery? YES/NO/Not Applicable

Have you already talked with your supervisor? \_\_\_\_\_

How are you planning to compensate for your lost wages? \_\_\_\_\_

**PSYCHIATRIC HISTORY**

Are you currently feeling suicidal? YES / NO

If so, do you have an associated plan? YES / NO

Please describe \_\_\_\_\_  
 \_\_\_\_\_

Have you felt suicidal at any time in your past? YES / NO

If so, when \_\_\_\_\_

Circumstances \_\_\_\_\_  
 \_\_\_\_\_

Have you ever been hospitalized for a mental illness or suicide attempt? YES / NO

Date(s) \_\_\_\_\_

Location(s) \_\_\_\_\_

Provider Name \_\_\_\_\_

Outcome \_\_\_\_\_

List all current and past counseling and psychiatric treatment:

Dates	Location	Provider	Diagnosis	Issues/Outcomes
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

List all current and past medications that you have taken for mental health reasons (e.g., depression, anxiety):

<i>Current</i>		<i>Past</i>	
Name	Dosage	Name	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If currently receiving mental health treatment:

Does your therapist/psychiatrist know that you are considering gastric bypass surgery? YES / NO

If yes, is he/she supportive of gastric bypass surgery? YES / NO

If no, why not? \_\_\_\_\_

Did your mental health provider write a letter to be included in your record? YES/NO/Will need to request

Will you see your mental health provider for therapy related to post-operative issues? YES / NO

If yes, please provide name and degree \_\_\_\_\_

If no, explain \_\_\_\_\_

Please check all symptoms that apply currently or that have been present during the past year:

- Depressed Mood
- Diminished interest/pleasure in daily activities
- Significant weight loss/gain (amount \_\_\_\_\_, time frame \_\_\_\_\_)
- Difficulty falling and/or staying asleep
- Difficulty getting out of bed
- Sleeping much more than usual
- A significantly decreased need for sleep
- Fatigue or loss of energy
- Feelings of worthlessness
- Difficulty concentrating
- Difficulty functioning with typical daily activities
- Excessive impulsive behaviors (sexually, financially, socially)
- More talkative than usual
- Racing thoughts/difficulty "turning your mind off"
- Panic/anxiety attacks (increased heart rate, sweating, trembling, difficulty breathing, chest pain, nausea, dizziness)
- Concern about having panic/anxiety attacks
- Increased anxiety in social situations
- General anxiety and/or worry that interferes with daily functioning
- Difficulty leaving your home due to anxiety
- Phobia(s) \_\_\_\_\_
- Intrusive thoughts that cause distress/anxiety
- Compulsive behavior(s) (e.g. hand washing, checking) \_\_\_\_\_
- Hearing things (e.g. voices) that are not there
- Seeing things that are not there
- Feeling things that are not there
- Feeling that others are out to get you

As an adult, did you witness or survive any significant traumas including major injury, death of a loved one, natural disaster, physical abuse, sexual assault, etc.? YES / NO Describe \_\_\_\_\_

Have you participated in any mental health treatment as a result of this experience? YES / NO

Dates	Location	Provider	Diagnosis	Issues/Outcomes
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**SUBSTANCE USE HISTORY**

Have you ever received counseling/treatment for a substance abuse related concern? YES / NO

Date(s) \_\_\_\_\_ Location(s) \_\_\_\_\_

Provider Name \_\_\_\_\_ Outcome \_\_\_\_\_

Have you ever participated in a 12-step program, such as A.A. or N.A.? YES / NO

Date(s) \_\_\_\_\_ Location(s) \_\_\_\_\_

Have you ever incurred legal problems on account of your substance use? YES / NO

Date(s) \_\_\_\_\_ Circumstances \_\_\_\_\_

Please indicate your substance use history:

	Frequency of Use (how often do you use this substance)	Quantity of Use (how much do you consume during each use)	Date of Last Use	Duration (how long have you used this substance)
Amphetamines				
Alcohol				
Caffeine				
Cocaine				
Hallucinogens				
Inhalants				
Marijuana				
Nicotine				
Opiates				
Sedatives				

**FOR CLINIC USE ONLY:**

4/03

This worksheet has been reviewed / completed by:

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