ATLANTA AREA PSYCHOLOGICAL ASSOCIATES, P.C.

BARIATRIC ADULT PSYCHOLOGICAL HISTORY

Name: _____ Date of Birth: _____ Address _____

Why I came for this visit:

_____

_____

SYMPTOM CHECKLIST

Who lives with you?

[ ] Live alone [ ] Spouse [ ] Partner

[ ] Live with roommate(s) [ ] Live with my kids

[ ] Other _____

Occupation: _____

Education: [ ] High School [ ] Some College

[ ] Graduated College - A.A. B.A. B.S.

[ ] Advanced Degree - Master's, Doctorate

[ ] Certificate in My Field

0 = This symptom not present at this time
1 = This symptom is present, bothers you a little, but not enough to be a problem
2 = Symptom present, bothers you and affects your quality of life, but able to function OK
3 = Moderate impact on quality of life and/or day-to-day functioning
4 = Significant impact on quality of life and/or day-to-day functioning
5 = Serious impact on quality of life, interferes with day-to-day functioning

Symptom	Severity	Symptom	Severity	Symptom	Severity
Depressed Mood	0 1 2 3 4 5	Hearing/Seeing Things	0 1 2 3 4 5	Guilty Feelings	0 1 2 3 4 5
Worrying	0 1 2 3 4 5	Feel I'm Being Watched	0 1 2 3 4 5	Lump in Throat	0 1 2 3 4 5
Difficulty Concentrating	0 1 2 3 4 5	Feel Others Are Against Me	0 1 2 3 4 5	Heart Racing	0 1 2 3 4 5
Angry Feelings	0 1 2 3 4 5	Loss of Interest in Things	0 1 2 3 4 5	Twitches, Spasms	0 1 2 3 4 5
Angry Behavior	0 1 2 3 4 5	Temper Outbursts	0 1 2 3 4 5	Knot in Stomach	0 1 2 3 4 5
Anxious/Nervous Feelings	0 1 2 3 4 5	Thoughts Coming Too Fast	0 1 2 3 4 5	Fear of Places	0 1 2 3 4 5
Panic Attacks	0 1 2 3 4 5	Trouble Remembering Things	0 1 2 3 4 5	Grinding of Teeth	0 1 2 3 4 5
Mind Going Blank	0 1 2 3 4 5	Thoughts of Hurting Myself	0 1 2 3 4 5	Back Pain	0 1 2 3 4 5
Poor Appetite/Weight Loss	0 1 2 3 4 5	Thoughts of Killing Myself	0 1 2 3 4 5	Nausea	0 1 2 3 4 5
Easily Annoyed/Irritated	0 1 2 3 4 5	Tiredness / Fatigue - Daytime	0 1 2 3 4 5	Cry Easily	0 1 2 3 4 5
Difficulty Falling Asleep	0 1 2 3 4 5	Sleeping Too Much	0 1 2 3 4 5	Chest Pain	0 1 2 3 4 5
Difficulty Staying Asleep	0 1 2 3 4 5	Excessive Weight Gain	0 1 2 3 4 5	Sweaty Palms	0 1 2 3 4 5
Difficulty Waking Up	0 1 2 3 4 5	Excessive Weight Loss	0 1 2 3 4 5	Avoid People	0 1 2 3 4 5

BARIATRIC ADULT PSYCHOLOGICAL HISTORY Name: _____

Current Weight: _____ **Bariatric Surgeon/Practice: _____**

Height: _____ **Surgeon Phone: _____ Fax: _____**

What have you tried, to lose weight?

[ ] Weight Watchers
[ ] Jenny Craig/Nutrisystem
[ ] Over-the-counter diet pills
[ ] Prescription diet pills
[ ] Doctor supervised diet
[ ] Fasting/Shakes
[ ] Atkins/Low Carb
[ ] Exercise/Personal Trainer
[ ] Other Weight Loss Approaches: _____

Medical Issues Related to Weight:

[ ] Pre-Diabetic **[ ] Diabetic: Type I Type II**
[ ] High blood pressure **[ ] High Cholesterol**
[ ] Joint or other pain **[ ] Arthritis**
[ ] Surgeries **[ ]Heart Problems/Circulation Problems**
[ ] Breathing Problems **[ ] Unable to Exercise**

[ ] Other Medical Problems: _____

Medications I take:

Medicine and Dosage	What for?

Medicine and Dosage	What for?

Reasons for Overeating:

[ ] Comfort, Reduce Sad Feelings
[ ] Reduce Anxiety or Fear
[ ] Self-Nurturing
[ ] Reduce Attention From Others
[ ] Reaction to Anger/Resentment
[ ] Not enough time to Prepare Healthy Food
[ ] Feel obligated / pushed to eat (as a guest)
[ ] I cook a lot for my family
[ ] "Sweet Tooth" – crave unhealthy foods
[ ] Other: _____

Others' Attitudes about my having the surgery:

[ ] Supportive
[ ] Not Supportive
[ ] Negative
[ ] Partner worried I will leave after weight loss
[ ] Other: _____

I have completed the following to qualify for bariatric surgery:

[ ] Initial Surgical Consultation [ ] Medical Clearance – Cardiac [ ] Bariatric Support Group
[ ] Nutritional Consultation [ ] Medical Clearance – Pulmonary

Has any other family member had problems with obesity? ☐ Yes ☐No

Which Family Member?	Relationship to You?	What was counseling for?

Have you ever been in counseling or seen a psychiatrist before? ☐ Yes ☐No

Name of Practitioner	Address of Practitioner	Phone	When?	How many Times?

Has any other family member seen a counselor or psychiatrist? ☐ Yes ☐No

Which Family Member?	Relationship to You?	What was counseling for?

Were you ever in a hospital for a psychiatric problem, or rehab for a drug/alcohol problem? ☐ Yes ☐No

Name of Facility	City and State of Facility	Facility Phone	When Were You There?	For How Long?

Has any other family member been in a program for a psychiatric or substance use disorder? ☐ Yes ☐No

Which Family Member?	Relationship to You?	What was it for?

Has any family member used psychiatric medications? _____

FAMILY HISTORY

Behavioral Health Problems - History of Family (check all that apply):

	Mother	Father	Sister	Brother	Aunt	Uncle	Children	Grandparents
Anger / Rage / Violence								
Alcohol / Drug Problems								
Anxiety / Worry								
Attention Deficit								
Bipolar / Mood Swings								
Depression								
Eating Disorder								
Obesity / Eating								
Obsessive or Hoarding								
Schizophrenia								
Suicide or Attempt								

BARIATRIC ADULT PSYCHOLOGICAL HISTORY Name: _____

Who was present during childhood?

	Entire Time	Part of Time	NOT at all
Mother	[ ]	[ ]	[ ]
Father	[ ]	[ ]	[ ]
Stepmother	[ ]	[ ]	[ ]
Stepfather	[ ]	[ ]	[ ]
Brother(s)	[ ]	[ ]	[ ]
Sister(s)	[ ]	[ ]	[ ]
Other:	[ ]	[ ]	[ ]

Other was: _____

Parents' current marital status:

[ ] still married to each other

[ ] separated for _____ years

[ ] divorced for _____ years

[ ] mother remarried ____ times

[ ] father remarried _____ times

[ ] mother living with someone

[ ] father living with someone

[ ] mother deceased for ___ years

[ ] father deceased for ____ years

Describe your parents:

	Father	**Mother**
Name	_____	_____
Work	_____	_____
School	_____	_____
Health	_____	_____

Describe your childhood family experience:

[ ] outstanding home environment

[ ] normal home environment

[ ] chaotic home environment

[ ] witnessed physical/verbal/sexual abuse ***toward*** others

[ ] experienced physical/verbal/sexual abuse ***from*** others

Describe your relationship with a step-parent or parent's partner:

_____

Your family's economic status:

[ ] Wealthy [ ] Poor

[ ] Middle Class [ ] Welfare

[ ] Working Class

Check all that characterize your childhood experience:

[ ] Loving/Supportive [ ] Stable [ ] Variable [ ] Unstable

[ ] Verbally Abusive [ ] Parents Argued a Lot [ ] Emotionally Abusive

[ ] Physically Abusive [ ] Little Memory of Childhood

Difficult or Traumatic Events that happened during your childhood: _____

_____

Age of leaving family home: _____ Reason for leaving: _____

CURRENT FAMILY STATUS

My Marital status:

[ ] single, never married
[ ] engaged _____ months
[ ] married for _____ years
[ ] divorced for _____ years
[ ] separated for ____years
[ ] divorce in process
[ ] live-in for _____ years
____ prior marriages (self)
____ prior marriages (partner)

My Intimate relationship:

[ ] never been in committed relationship
[ ] not currently in committed relationship
[ ] currently in a committed relationship

Relationship satisfaction:

[ ] very satisfied with relationship
[ ] satisfied with relationship
[ ] partially satisfied with relationship
[ ] dissatisfied with relationship
[ ] very dissatisfied with relationship

List all persons currently living in your household:

_____

_____

_____

Children who visit: _____

_____

Describe any past or current problems in committed or romantic relationships: _____

_____

Describe any past or current problems in family relationships: _____

_____

Do you feel that you have a purpose in life? Y N Were you raised with a religion? Y N Denomination? _____

Do you currently attend religious activities? Y N Denomination? _____

Do you currently practice any spiritual activities such as meditation, etc. Y N _____

MEDICAL HISTORY (check all that apply)

Describe current physical health:

[ ] Excellent [ ] Good [ ] Fair [ ] Poor

List name of primary care physician:

Name _____ Phone _____

List name of psychiatrist: (if any):

Name _____ Phone _____

Date of last Physical Exam: _____

List any abnormal lab test results:

Date _____ Result _____

Date _____ Result _____

Is there a history of any of the following in your family:

[ ] tuberculosis [ ] heart disease [ ] behavior problems

[ ] birth defects [ ] high blood pressure [ ] alcoholism

[ ] drug abuse [ ] thyroid problems [ ] diabetes

[ ] cancer [ ] Alzheimer's disease/dementia

[ ] stroke [ ] mental disability

[ ] other chronic or serious health problems: _____

_____

Describe any serious hospitalization or accidents you have had:

_____

_____

CHRONIC PAIN PROBLEMS (check all that apply)

Choose a number from 0-10 that best describes your ongoing pain (circle) 0 1 2 3 4 5 6 7 8 9 10

Where is the pain located?_____ **When did the pain start?** _____

How long have you had this pain? _____ **How often do you experience pain?** _____

Does the pain affect activities (walking, shopping , exercise, etc)? _____

What makes the pain increase? _____ **What makes the pain decrease?** _____

OTHER HEALTH ISSUES (check all that apply):

Allergies? Food Allergies: Y N **Medication Allergies: Y N** **Environmental Allergies: Y N**

_____ _____ _____

Describe any health problems or issues you had during childhood: _____

_____

SOCIO-ECONOMIC SITUATION (check all that apply)

Living situation:

[ ] housing is adequate
[ ] no stable home
[ ] housing overcrowded
[ ] dependent on others
[ ] housing dangerous/deteriorating
[ ] living companions dysfunctional
[ ] drinking/drugs used in the home

Social support system:

[ ] supportive network
[ ] few or no friends
[ ] distant from parents/siblings
[ ] isolate myself
[ ] just my romantic partner
[ ] friends have similar prob's

Sexual history:

[ ] heterosexual orientation
[ ] homosexual orientation
[ ] bisexual orientation
[ ] currently sexually active
[ ] currently sexually satisfied
[ ] currently sexually dissatisfied
[ ] sexually transmitted disease
[ ] NOT currently sexually active
[ ] age of first sexual experience _____
[ ] history of promiscuity
[ ] history of unsafe sex
[ ] terminated pregnancy
[ ] age at first pregnancy/fatherhood ___
[ ] history of miscarriage

Additional information: _____

Employment:

[ ] employed and satisfied
[ ] employed and unsatisfied
[ ] unemployed now
[ ] often unemployed
[ ] coworker conflicts
[ ] supervisor conflicts
[ ] lost several jobs
[ ] disabled

Military history:

[ ] never in military
[ ] military – Hon. Discharge
[ ] military – other Discharge
[ ] discipline problems
[ ] problems after discharge
[ ] Post-Traumatic Stress

Cultural/spiritual/recreational history:

Cultural identity? (ethnicity, religion): _____

Community/Recreational activities? **Y N** _____

Still Participate? **Y N** _____

Legal history:

Financial situation:

[ ] no current financial problems
[ ] poverty or below-poverty income
[ ] lots of debts
[ ] impulsive spending
[ ] relationship conflicts over finances

[ ] no legal problems
[ ] arrested as juvenile
[ ] arrested as adult
[ ] spent time in jail

[ ] now on parole/probation
[ ] court ordered this treatment/evaluation
[ ] total time served: _____

Describe any current legal difficulty: _____

PERSONAL INSIGHT

Strengths:

_____

_____

Weaknesses:

_____

_____

What I Need To Work On:

_____

_____

Please complete the following sentences:

I feel angry/ resentful because _____

I am afraid of _____

I feel hopeless about _____