CONSENT TO TESTING & CONTRACT FOR BARIATRIC SURGERY EVALUATION

- I am aware that a pre-operative psychological evaluation is required. This evaluation will consist of an extended clinical interview and psychological assessment. I understand the initial intake evaluation will take approximately 90 minutes. Due to the extensive nature of the evaluation, 2 or more office visits may be required to complete the process.
- I understand the Bariatric Center staff reserves the right to cancel or reschedule clients who may present as unprepared for the pre-operative psychological evaluation including those arriving late, missing pre-visit paperwork, or accompanied by minor children.
- I consent to take part in testing for the purpose of accurate diagnosis and treatment planning. I understand it is in my best interest to actively participate in testing and to follow the treatment recommendations that result from this process.
- I understand it is important that I am completely honest with my evaluator so that she can make an informed decision and provide me with the optimal level of care as I go through this process. I understand my evaluator wants to ensure my success with surgery. I agree to read each test item carefully and answer honestly. **Testing Note: In approaching the test taking process try to avoid over-thinking items, as it is best to go with your initial response to each question. Honesty is of utmost importance, as some forms of testing can detect dishonest and/or defensive responding. Realize that it is normal and expected for people to report problems. If your test results are found to be invalid, this may interfere with our ability to make a decision regarding appropriate treatment or, if applicable, to make recommendations for surgery.**
- I understand I have the right to refuse or discontinue testing at any time. However, doing so could impede effective diagnosis and treatment planning.
- I understand my psychological evaluation report will be released to my doctor and to my insurance company for further review, and that they will ultimately determine whether or not I am approved for surgery.
- I understand my clinician and surgeon will be sharing treatment recommendations. I am aware that the result of this evaluation is a recommendation regarding my appropriateness for surgery and the level of support I may need in order to optimize my success with the surgery.
- I understand neither raw test data nor the psychological report will be released directly to me. I am aware that if I desire feedback or an interpretation of my testing, I will need to schedule an additional session with the clinician who performed the evaluation.
- I understand there is no guarantee that any particular outcome will result from testing.
- I understand the evaluation includes a clinical interview, psychological testing, interpretation of tests, collaboration with other providers, and preparation of the psychological report.

If you have any questions or concerns, please address them with your evaluator and/or the office manager before signing. **My signature indicates that I understand and agree to all of the above.**

Client/Representative Signature: ____Date ______________________

Print Name:____Date:_____________________

I have addressed the client's/parent's/guardian's concerns and/or questions. The client appears fully competent to give informed consent.

Staff Signature ____Date ______________________

The Bariatric Center Pre-Operative Client Information

Prior to your scheduled visit, please complete each section to help your clinician provide appropriate services. In accordance with our professional codes of ethics and state and federal laws, any information you provide is strictly confidential.

Name: ________________________________ **Date of Birth:** _______________**Todays Date:** ___________________

Mailing Address: ____

City: ___________________________________ State: _______________ Zip Code: ___________________

Referral Information:
Who referred you for this evaluation: ____
What procedure are you considering? ____
Have you previously received psychological evaluation for weight loss surgery, or other procedure? Yes No
If yes, when? ____

Employment Information:
Are you currently employed? Yes No
If yes, where are you employed? ____
Job title/responsibilities? ____

Education Information:
Highest Level of Education Completed:
Grade School __________ High School ______ College _______ Graduate School _____________

Are you currently a student? Yes No
If yes, where? ___________________________________ Year _______________ Major ___________________________

Family/Significant Others:
Please provide the following information about your family members (include parents, stepparents, all siblings, spouse/partner, children, etc.) and significant others.

Name	Relationship to You	Age	Where He/She Lives	History of Mental/Medical Conditions (mental illness, substance abuse, eating disorder, obesity)

Current Medications, Supplements, Vitamins	Daily Dose	Start Date	Name of Prescriber

Physical Symptoms/Medical Conditions:

Which of the following are you currently experiencing/have you been diagnosed with?

_______ loss of period
_______ irregular period
_______ nausea
_______ dizziness
_______ tingling
_______ numbness
_______ fatigue
_______ trouble sleeping
_______ gas
_______ cramps
_______ bloating
_______ diarrhea
_______ constipation

_______ ulcers
_______ chest pain
_______ irregular heartbeat
_______ shortness of breath
_______ frequent urination
_______ dehydration
_______ water retention
_______ excessive thirst
_______ swelling of ankles
_______ swelling of hands
_______ headaches/migraines
_______ excessive sweating
_______ PCOS

_______ infertility
_______ anemia
_______ acid reflux/GERD
_______ diabetes
_______ hypoglycemia
_______ hypothyroid
_______ high cholesterol
_______ hypertension
_______ joint pain
_______ cardiac issues
_______ sleep apnea
other: ______________________
____

Last physical exam: when, where, and with whom? ____

Listed below are a few common reasons people want to have surgery. Please rate how important each one is to your desire to have this surgery? **Circle your <u>most</u> important reason.**

	Not at all	Slightly	Moderately	Considerably	Extremely	N/A
Increase mobility						
Increase energy						
Resume/adopt new activities						
Improve social life						
Enhance occupational functioning						
Improve health						
Prevent future health problems						
Increase life expectancy						
Decrease pain						
Feel better						
Improve appearance						
Improve self-esteem						
Improve sex life						
Improve relationship w/ significant other						
Practical reasons/Quality of life						
Other (describe):						

Weight Loss Surgery Preparation:

How long have you been thinking about having weight loss surgery? ______________________________

Have you currently working with the NKCH Bariatric Dietician? Yes No If yes, date started: ________________

Weight History:

Height ________________ Current Weight ______________ Desired Weight _______

Lowest Weight ________ Date/age of this weight_______

Highest Weight _______ Date/age of this weight_______

Weight History:

When did you first have a problem with weight? (childhood, adolescence, pregnancy, etc.) ________________________

____

What do you think are the main contributors to your weight? (i.e. genetics, poor food choices, lack of exercise, medications, etc.)?____

How has your weight been affecting you lately? ____

Diet history (please list):

Name/type of diet plan:	How long did you follow this plan?	How much weight did you lose?

Current Daily Intake (average over the past 6 months):

How many meals or snacks do you eat in a typical day? ____

Do you tend to eat planned meals and snacks, or do you find that you eat continuously during the day or evening?______

____

Are your portion sizes typically small, medium, or large? Please give examples. ___________________________________

Are there specific times/situations you are more likely to eat larger portions? ____________________________________

How often do you drink caloric beverages like soda, juice, sweet tea, sports drinks, or energy drinks?_________________

How often do you eat fast food?____________________ times per **week** or **month** (circle which applies)

How often do you eat at restaurants? _______________ times per **week** or **month** (circle which applies)

How often do you eat take-out? ___________________________ times per **week** or **month** (circle which applies)

How often do you eat dessert? _____________________ times per **week** or **month** (circle which applies)

Emotional eating

Do you find that you frequently (more than 2x/week) eat in response to negative emotions? Y N

Do you find that you frequently (more than 2x/week) use food as a coping mechanism? Y N

Do you find that you frequently (more than 2x/week) use food to calm yourself? Y N

Do you feel that eating in response to stress or emotions contributes to your weight or makes it hard for you to lose weight? Y N

Night eating

Do you find that you're not hungry when you wake up in the morning? Y N

Do you think that the majority of your calories are eaten after dinner? Y N

Do you ever wake up in the middle of the night and eat? Y N

If so, what types of foods do you eat?____

Mindless eating

Which of the following do you do more than 2 times per week?

_______ eat while driving

_______ eat while at your computer or on your phone

_______ finish a portion of food and didn't realize you ate it

_______ eat in front of the TV

_______ eat in your bed

_______eat standing up

Purging/Weight Control Measures:

Behaviors	Past	Current	# of times/pills per day	# of days per week
Vomiting	_______	_______	____________________	____________________
Diet Pills	_______	_______	____________________	____________________
Laxatives	_______	_______	____________________	____________________
Diuretics	_______	_______	____________________	____________________

Mental Health History:

Are you currently under the care of a psychiatrist, mental health therapist, or other provider for the treatment of any psychiatric or mood related concerns including medication management or mental health therapy? Yes No

If yes; with whom? What treatment/service do you receive?
____

Have you ever experienced any of the following?

_______ A recent and/or important loss (please specify)____

_______ Physical Abuse

_______ Sexual Abuse/Molestation

_______ Sexual Assault

_______ Verbal/Emotional Abuse

_______ Suicidal Thoughts or Feelings

_______ Homicidal Thoughts or Feelings

Are you having current difficulties with any of the following?

_______ Self-Confidence/Self-Esteem

_______ Body Image

_______ Anger Management

_______ Romantic Relationships

_______ Family Relationships

_______ Divorce/Separation

_______ Legal Problems

_______ Financial Problems/Unemployment

_______ Learning Disabilities

_______ Loneliness/Social Isolation

_______ Career Planning

_______ Spirituality

_______ Decision Making

_______ Pregnancy (past, present

_______Other stress (please specify)____

How well are you getting along psychologically at this time?

____________ Very well, the way I want to

____________ Quite well, no important complaints.

____________ Fairly well, but have ups and downs.

_______ So-so, can keep going with effort.

_______ Quite poorly, can barely manage.

_______ Very poorly, can’t manage.

SYMPTOM CHECKLIST

Instructions: The questions below ask about things that might have bothered you or caused problems. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**. If the problem has happened in the past, even if it is resolved, please check "In the past."

		During the past TWO (2) WEEKS, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	Leave Blank
I	1	Little interest or pleasure in doing things?	0	1	2	3	4	
	2	Feeling down, depressed, empty or hopeless?	0	1	2	3	4	
II	3	Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III	4	Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5	Starting more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV	6	Feeling nervous, anxious, frightened, worried, or on edge for days at a time, even when you didn't have anything special to do?	0	1	2	3	4	
	7	Feeling panic or being frightened?	0	1	2	3	4	
	8	Avoiding situations that make you anxious?	0	1	2	3	4	
V	9	Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10	Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
V	11	Thoughts of actually hurting yourself?	0	1	2	3	4	
VII	12	Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13	Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII	14	Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX	15	Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X	16	Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
VII	17	Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI	18	Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII	19	Not knowing who you really are or what you want out of life?	0	1	2	3	4	

		During the past TWO (2) WEEKS, how much (or how often) have you been bothered by the following problems?	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Leave Blank
	20	Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII	21	Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22	Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
XIIII	23	Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	
	24	Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	25	Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	26	Anyone remarking on or expressed concern about your use of alcohol or drugs?	0	1	2	3	4	
	27	Having drug or alcohol use cause other problems in your life?	0	1	2	3	4	
X	28	Being very worried or upset about something that happened to you, such as the death of a loved one, losing a job, getting separated or divorced, having a bad accident, getting a serious illness, etc.?	0	1	2	3	4	
		Having more trouble handling these situations than most people would?	0	1	2	3	4	
	29	Having flashbacks in which you found yourself reliving some terrible experience over and over?	0	1	2	3	4	
XI	30	Feeling fat even when other people express concern that you are thin enough or too thin?	0	1	2	3	4	
	31	Eliminating foods or restricting your overall food intake?	0	1	2	3	4	
	32	Eating so much you make yourself feel sick?	0	1	2	3	4	

		During the past TWO (2) WEEKS, how much (or how often) have you been bothered by the following problems?	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Leave Blank
	33	Eating to comfort, soothe, reward, or punish yourself?	0	1	2	3	4	
	34	Feeling that your eating was excessive and/or not really normal?	0	1	2	3	4	
	35	Feeling out of control when eating?	0	1	2	3	4	
	36	Worrying all the time about food or weight issues?	0	1	2	3	4	
	37	Feeling depressed, ashamed, or disgusted after eating?	0	1	2	3	4	
	38	Vomiting, using laxatives or diuretics, or exercising excessively to try to make up for eating too much?	0	1	2	3	4	
	39	Other feelings or symptoms that we have not mentioned? Specify:						

Have any of these symptoms -- drinking, drug use, moods, anxiety, etc. – ever interfered with school, work, or your job? What concerns, if any, have family and friends expressed? Please explain. ________________________________

____

Have any of these symptoms ever gotten you into trouble with the authorities and/or caused legal problems? If yes, please explain. ____

____

Has your health ever suffered as a result of any of these symptoms? If yes, please explain. ____________________

____

Have you ever received medication or treatment for any of these symptoms? If yes, please explain. _____________

____

Were you ever hospitalized for any of these symptoms? If yes, please explain. Please list any hospitalizations for psychological, psychiatric, or chemical dependency treatment, including location and dates. ____________________

____

Yale Food Addiction Scale

This survey asks about your eating habits in the past year. People sometimes have difficulty controlling their intake of certain foods such as:

- Sweets like ice cream, chocolate, doughnuts, cookies, cake, candy, ice cream
- Starches like white bread, rolls, pasta, and rice
- Salty snacks like chips, pretzels, and crackers
- Fatty foods like steak, bacon, hamburgers, cheeseburgers, pizza, and French fries
- Sugary drinks like soda pop

When the following questions ask about **"CERTAIN FOODS"** please think of ANY food similar to those listed in the food group or ANY OTHER foods you have had a problem with in the past year.

IN THE PAST 12 MONTHS:	Never	Once a month	2-4 times a month	2-3 times a week	4 or more times a week or daily
1. I find that when I start eating certain foods, I end up eating much more than planned	0	1	2	3	4
2. I find myself continuing to consume certain foods even though I am no longer hungry	0	1	2	3	4
3. I eat to the point where I feel physically ill	0	1	2	3	4
4. Not eating certain types of food or cutting down on certain types of food is something I worry about	0	1	2	3	4
5. I spend a lot of time feeling sluggish or fatigued from overeating	0	1	2	3	4
6. I find myself constantly eating certain foods throughout the day	0	1	2	3	4
7. I find that when certain foods are not available, I will go out of my way to obtain them. For example, I will drive to the store to purchase certain foods even though I have other options available to me at home.	0	1	2	3	4
8. There have been times when I consumed certain foods so often or in such large quantities that I started to eat food instead of working, spending time with my family or friends, or engaging in other important activities or recreational activities I enjoy.	0	1	2	3	4
9. There have been times when I consumed certain foods so often or in such large quantities that I spent time dealing with negative feelings from overeating instead of working, spending time with my family or friends, or engaging in other important activities or recreational activities I enjoy.	0	1	2	3	4
10. There have been times when I avoided professional or social situations where certain foods were available, because I was afraid, I would overeat.	0	1	2	3	4
11. There have been times when I avoided professional or social situations because I was not able to consume certain foods there.	0	1	2	3	4
12. I have had withdrawal symptoms such as agitation, anxiety, or other physical symptoms when I cut down or stopped eating certain foods. (Please do NOT include withdrawal symptoms caused by cutting down on caffeinated beverages such as soda pop, coffee, tea, energy drinks, etc.)	0	1	2	3	4
13. I have consumed certain foods to prevent feelings of anxiety, agitation, or other physical symptoms that were developing. (Please do NOT include consumption of caffeinated beverages such as soda pop, coffee, tea, energy drinks, etc.)	0	1	2	3	4
14. I have found that I have elevated desire for or urges to consume certain foods when I cut down or stop eating them.	0	1	2	3	4
15. My behavior with respect to food and eating causes significant distress.	0	1	2	3	4
16. I experience significant problems in my ability to function effectively (daily routine, job/school, social activities, family activities, health difficulties) because of food and eating.	0	1	2	3	4

Yale Food Addiction Scale

IN THE PAST 12 MONTHS:	NO	YES
17. My food consumption has caused significant psychological problems such as depression, anxiety, self-loathing, or guilt.	0	1
18. My food consumption has caused significant physical problems or made a physical problem worse.	0	1
19. I kept consuming the same types of food or the same amount of food even though I was having emotional and/or physical problems.	0	1
20. Over time, I have found that I need to eat more and more to get the feeling I want, such as reduced negative emotions or increased pleasure.	0	1
21. I have found that eating the same amount of food does not reduce my negative emotions or increase pleasurable feelings the way it used to.	0	1
22. I want to cut down or stop eating certain kinds of food.	0	1
23. I have tried to cut down or stop eating certain kinds of food.	0	1
24. I have been successful at cutting down or not eating these kinds of foods	0	1

25. How many times in the past year did you try to cut down or stop eating certain foods altogether?	1 time	2 times	3 times	4 times	5 or more times

26. Please circle ALL of the following foods you have problems with:							
Ice cream	Chocolate	Apples	Doughnuts	Broccoli	Cookies	Cake	Candy
White Bread	Rolls	Lettuce	Pasta	Strawberries	Rice	Crackers	Chips
Pretzels	French Fries	Carrots	Steak	Bananas	Bacon	Hamburgers	Cheeseburgers
Pizza	Soda Pop	None of the above					

27. Please list any other foods that you have problems with that were not previously listed:

Other questions or concerns that have not been specifically addressed: ____

____

Acknowledgement: Portions of this document have been adapted with permission from the Chrysalis Center for Counselling and Eating Disorder Treatment Bariatric Intake Form, Wilmington, North Carolina © 2010. All rights reserved. Further assessment consideration includes: The Yale Food Addiction Scale (Gearhardt, Corbin, Brownell, 2009 Contact: ashley.gearhardt@yale.edu). [REV: 02.01.2019]