



Psychological ARTS

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Please print this form and fill out the following information to the best of your ability. It is important that you bring this form with you when you attend your psychological evaluation. If you do not have access to a printer, it will be necessary for you to come 45 minutes early to your appointment to fill out this paperwork. *If you forget to bring your form to the appointment, your appointment may need to be rescheduled.*

How tall are you? _____

How much do you weight currently? _____

What is the lowest (adult) weight you ever attained (through deliberate effort)?

(Weight attained) _____

For how long did you maintain this weight? _____

(If different from above),

how long do you typically maintain a major weight loss? _____

What is the highest your weight has ever been, and when was this?

Weight _____ Date/age _____

Think about a typical day. Please list all of the foods/meals you eat during a typical day, including snacks.

When you have tried to lose weight in the past, has anything worked well? How long did it take, and how long did you keep it off? What was it that made that method helpful? What factors led to weight regain?

(For each method that has worked well, record the approximate date, how much weight loss was achieved, how long it took to achieve weight loss, how long weight loss was maintained, what led to regain, and what factors made this method successful/what they liked or disliked about it.)

Year	Method	Amount Lost	Time to achieve	Time maintained	Regain trigger(s)	Helpful factors

Use the space below if you need more room to write the above information.

***Is there anything you have tried in the past to lose weight that did not work well?
Why do you think it was not effective?***

(For each method that has not worked well, record the approximate date, how long it was tried, what the result was (e.g., lost only 5# and “gave up”), and the patient’s theories about why this method did not work

Year	Method	Result	Duration	Why not effective

Use the space below if you need more room to write the above information.

Food Preferences and Sources

Do you have a certain type of food(s) that you consider your “weakness(es)”?

How often do you drink high-calorie beverages like soda, juice, sports drinks, of other sweet drinks?

Who shops for and prepares most of your food?

Where do you get meals when you are at school/work?

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

Eating patterns

<i>Do you have a regular eating pattern?</i>	(Y/N?)
<i>What is it?</i>	
<i>How many meals or snacks do you eat in a typical day?</i>	
<i>What is the timing of your meals and snacks?</i>	
<i>Do you frequently go more than 3-4 hours without eating anything?</i>	(Y/N?)
(If yes) <i>Does this lead to eating more the next time you eat?</i>	(Y/N?)
<i>Do you tend to eat when you are bored?</i>	(Y/N?)

Have you ever had a time when you've eaten a very large amount of food (i.e., a lot more than most people would eat in a similar situation) in a short space of time (say, under two hours)?

What did you eat last time this happened (specify amount)?

Did you feel out of control while you were eating this way? Did you feel you could not stop?

Do you or have you ever tried to control your weight by “getting rid of” what you’d eaten in any of the following ways?

Purging	Current	Past (Specify when)	Frequency (e.g., 2x/wk)	Duration (e.g., 6 months)
Self-induced vomiting				
Laxatives (2+ times normal dose)				
Diuretics (2+ times normal dose)				
Diet pills (2+ times normal dose)				
Excessive exercise				
Other (Specify: _____)				

Grazing

Do you tend to eat set meals and snacks, or do you find that you have times when you will eat continuously during the day or the evening?

___ Yes ___ No

(If yes) **When is this most likely to happen?**

<u>Emotional Eating</u>	
Do you find that you frequently (> 2x/wk) eat in response to negative emotions?	
Do you find that you frequently (> 2x/wk) use food as a coping mechanism?	
Do you find that you frequently (> 2x/wk) use food to calm or “medicate” yourself?	
Are your current emotions or stressors contributing to your weight by causing you to eat more?	
Do you feel that eating in response to emotions contributes significantly to your weight or makes it difficult to lose weight?	

Night Eating	
1. Do you ever wake up in the middle of the night?	(Y/N)
1a. When you wake up in the middle of the night, how often do you eat at that time?	(≥ 3 times/week? Y/N)
2. Do you think that at least a quarter of your day's calories are eaten after dinner?	(use food record to evaluate, if possible) (Y/N) If no to both 1a and 2, stop here
3. Do you find that you are not hungry when you wake up in the morning?	(Y/N)
4. Are you very distressed by this pattern of eating?	(Y/N)

What do you think are the main contributors to your weight? (e.g., genetics, poor food choices, large portions, meal/snack patterns, emotional eating, time constraints, lack of exercise, smoking cessation, medications, menopause, other medical conditions, etc.)

I'm going to list a few reasons why some people want to have weight loss surgery. On a scale of 1-5, how important is each one to your desire to have this surgery? Which one is the most important reason?

1 = Not At All 2 = Slightly 3 = Moderately
4 = Considerably 5 = Extremely N/A = Not Applicable

Circle the most important reason

- Increased mobility _____
- Increased energy _____
- Resume/adopt new activities _____
- Improved social life _____
- Enhanced occupational functioning _____
- Improved health _____
- Prevent future health problems _____
- Increased longevity _____
- Decreased pain _____
- Feel better _____
- Improved appearance _____
- Improved self-esteem _____
- Improved sex life _____
- Improved relationship with partner or spouse _____
- Practical reasons (fit into airplane seat, tie shoes, clothes shopping, etc.) _____
- Other (describe _____) _____

Do you have any medical/physical health problems currently?

List any medications that you are currently taking.

Have you ever received a mental health diagnosis or had a psychiatric/psychological problem (e.g., depression, anxiety)?

Have you ever been in psychological treatment (e.g., counseling)?

Is there any history in your family of mental health/psychiatric problems?

Has anyone else in your family struggle with weight/trying to lose weight?

- Alcohol

What is your current use of alcohol?

(If no current problem drinking): **Has there ever been a time in the past when you were drinking more at a time, or more frequently?**

(If applicable): **Has (current/past) use of alcohol ever created any problems for you?**

- Drugs

What is your current use of drugs?

(If present, assess with regard to DSM criteria for abuse/dependence)

Have you ever used any drug regularly in the past?

(If yes, assess with regard to DSM criteria for abuse/dependence)

- Smoking

Do you currently smoke cigarettes?

(If yes): **How long have you been smoking?**

(If yes): **How many cigarettes do you smoke on a typical day?**

(If yes): **How would it be for you to stop smoking if your surgeon required it?**

Thank you for completing this form. Please remember to bring this completed form with you to your appointment.