TuftsMedicine
Lowell General Hospital

Center for Weight Management and Bariatric Surgery
20 Research Place, #120
N. Chelmsford, MA 01863
T **978.788.7200**
tuftsmedicine.org

Psychological Questionnaire

Please complete this questionnaire and bring it with you to your first appointment.

Name: ______________________________ **Date:** ______________

Date of Birth: ______________________ **Surgeon:** ______________________

I am interested in:
☐ Gastric Bypass ☐ Gastric Sleeve ☐ Conversion ☐ Medical Weight Loss ☐ Unsure

Personal Information

Marital Status: ☐ Single ☐ Married ☐ Live-in partner ☐ Dating someone ☐ Remarried
☐ Widowed ☐ Divorced ☐ Separated

Children (include ages):____

Who do currently live with? ____

Are you sexually active? **Yes** **No**

Are you planning to become pregnant within the next two years? **Yes** **No**

Do you use contraception? **Yes** **No** If Yes, what method: ______________________

Work status: ☐ Employed ☐ Unemployed ☐ Disabled ☐ Self-employed
☐ Homemaker ☐ Other:______________________________________

List last three places of employment:

Job Title: ______________________________# of years__ ____________

Job Title: ______________________________# of years__ ____________

Job Title: ______________________________# of years__ ____________

Weight and Eating Patterns

When did you begin to put on weight?
☐ Childhood ☐ Adolescence ☐ Early Adulthood ☐ Adulthood ☐ After pregnancy/children
☐ After a significant event in my life

Which statement best describes your weight gain?
☐ Slow and Steady over several years
☐ Gained most of my excess weight in less than 12 months
☐ I've been this big all of my adult life

What is the most amount of weight you have ever lost?_______________

How long were you able to maintain this weight loss? _______________

Eating Survey*

The following questions ask about your eating patterns and behaviors within the last 3 months. For each question, choose the answer that best applies to you.

1. During the past 3 months, did you have any episodes of excessive overeating (i.e., eating significantly more than what most people would eat in a similar period of time)? ☐ Yes ☐ No

NOTE: IF YOU ANSWERED "NO" TO QUESTION 1, YOU MAY STOP. THE REMAINING QUESTIONS DO NOT APPLY TO YOU.

2. Do you feel distressed about your episodes of excessive overeating? ☐ Yes ☐ No

Within the past 3 months . . .

3. During your episodes of excessive overeating, how often did you feel like you had no control over your eating (e.g., not being able to stop eating, feel compelled to eat, or going back and forth for more food)?	☐ Never or Rarely	☐ Sometimes	☐ Often	☐ Always
4. During your episodes of excessive overeating, how often did you continue eating even though you were not hungry?	☐ Never or Rarely	☐ Sometimes	☐ Often	☐ Always
5. During your episodes of excessive overeating, how often were you embarrassed by how much you ate?	☐ Never or Rarely	☐ Sometimes	☐ Often	☐ Always
6. During your episodes of excessive overeating, how often did you feel disgusted with yourself or guilty afterward?	☐ Never or Rarely	☐ Sometimes	☐ Often	☐ Always
7. During the last 3 months, how often did you make yourself vomit as a means to control your weight or shape?	☐ Never or Rarely	☐ Sometimes	☐ Often	☐ Always

*BEDS-7

Attitude Toward Surgery

What do you think are the possible side effects or complications of the surgery?

____

How do your family, friends, loved ones feel about your having the surgery?

____

____

What arrangements have you made for recovery after surgery (i.e., child care, meal preparation, time off from work)?

____

____

Do you have long-term or short-term disability insurance? **Yes** **No**

How much time do you plan on taking to recover? ________________________________

Current Life Stressors (check all that apply)

- ☐ No significant stressors
- ☐ Death of spouse
- ☐ Divorce
- ☐ Jail/legal issues
- ☐ Marriage
- ☐ Fired from job
- ☐ Retirement
- ☐ Pregnancy
- ☐ Marital separation
- ☐ Break-up
- ☐ Marital reconciliation
- ☐ Personal injury or illness
- ☐ Death of a close family member
- ☐ Increased marital arguments
- ☐ Addition to family
- ☐ Change in financial status
- ☐ Death of a close friend
- ☐ Financial debt
- ☐ Layoff/reorganization at work
- ☐ Other:______________________
- ☐ Career change
- ☐ Mortgage foreclosure
- ☐ Change in living conditions
- ☐ Fertility treatments
- ☐ Change in work hours and/or conditions
- ☐ Change in family member's health
- ☐ Bankruptcy/credit counseling
- ☐ Son or daughter leaving home
- ☐ Sexual difficulties

Have you ever seen things that other people did not see? **Yes** **No**

If yes, describe the situation: ____

____

____

Have you ever heard voices when no one was around? **Yes** **No**

If yes, describe the situation: ____

____

____

Have you ever had a belief or idea that your family or friends never understood? **Yes** **No**

If yes, describe the situation: ____

____

____

Previous Mental Health Treatment

Have you ever participated in counseling or psychotherapy? **Yes** **No**

If yes, provide treatment provider(s) name(s)/location(s):

____

____

____

Did you find this treatment effective? **Yes** **No**

Have you ever been hospitalized for depression, anxiety or other mental illness? **Yes** **No**

If yes, provide treatment facility name(s)/location(s):

____

____

____

Did you find this treatment effective? **Yes** **No**

Have you ever been prescribed antidepressant, antianxiety, or other psychiatric medication? **Yes** **No**

If yes, provide treatment provider(s) name(s) and location(s):

____

____

____

Did you find this treatment effective? **Yes** **No**

Current psychiatric medications:

____

____

____

Substance Use

Check all substances that you have used:

- ☐ Marijuana, hashish
- ☐ Narcotics (e.g., heroin, morphine, opium)
- ☐ Stimulants (e.g., speed, Ecstasy, Molly, meth)
- ☐ Cocaine, Crack
- ☐ Sedatives (e.g., valium, Quaalude)
- ☐ Hallucinogens (e.g., LSD, Mescaline)
- ☐ Solvents (e.g., glue)
- ☐ Bath Salts

Alcohol Use*

Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals:

12 oz. beer 5 oz. wine 1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year

Have you ever been in treatment for an alcohol problem? ◯ Never ◯ Currently ◯ In the past

*AUDIT

Symptoms Surveys

Read each item in the list below. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not at all	**Mildly It didn't bother me much.**	**Moderately It wasn't pleasant at times.**	**Severely It bothered me a lot.**
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding/racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky / unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot/cold sweats	0	1	2	3
Column Sum				

Please read the entire group of statements in each box. Then pick out the ONE statement in that group that best describes the way you have been feeling in the past TWO weeks, including today. Put a check beside the statement you have chosen. If several statements in the group apply, choose the statement with the highest number for that group. DO NOT choose more than ONE statement for any group.

__ 0 I do not feel sad. __ 1 I feel sad. __ 2 I am sad all the time and I can't snap out of it. __ 3 I am so sad and unhappy that I can't stand it	__0 I am no more irritated by things than I ever was. __1 I am slightly more irritated now than usual. __2 I am quite annoyed or irritated a good deal of the time. __3 I feel irritated all the time.
__0 I have not lost interest in other people. __1 I am less interested in other people than I used to be. __2 I have lost most of my interest in other people. __3 I have lost all of my interest in other people.	__0 I make decisions about as well as I ever could. __1 I put off making decisions more than I used to. __2 I have greater difficulty in making decisions more than I used to. __3 I can't make decisions at all anymore.
__0 I am not particularly discouraged about the future. __1 I feel discouraged about the future. __2 I feel I have nothing to look forward to. __3 I feel the future is hopeless and that things cannot improve.	__0 I do not feel like a failure. __1 I feel I have failed more than the average person. __2 As I look back on my life, all I can see is a lot of failures. __3 I feel I am a complete failure as a person.
__0 I get as much satisfaction out of things as I used to. __1 I don't enjoy things the way I used to. __2 I don't get real satisfaction out of anything anymore. __3 I am dissatisfied or bored with everything.	__0 I don't feel that I look any worse than I used to. __1 I am worried that I am looking old or unattractive. __2 I feel there are permanent changes in my appearance that make me look unattractive __3 I believe that I look ugly.
__0 I don't feel particularly guilty. __1 I feel guilty a good part of the time. __2 I feel quite guilty most of the time. __3 I feel guilty all of the time.	__0 I can work about as well as before. __1 It takes an extra effort to get started at doing something. __2 I have to push myself very hard to do anything. __3 I can't do any work at all.
__0 I don't feel disappointed in myself. __1 I am disappointed in myself. __2 I am disgusted with myself. __3 I hate myself.	__0 I don't get more tired than usual. __1 I get tired more easily than I used to. __2 I get tired from doing almost anything. __3 I am too tired to do anything.
__0 I don't feel I am any worse than anybody else. __1 I am critical of myself for my weaknesses or mistakes. __2 I blame myself all the time for my faults. __3 I blame myself for everything bad that happens.	__0 My appetite is no worse than usual. __1 My appetite is not as good as it used to be. __2 My appetite is much worse now. __3 I have no appetite at all anymore.

__0 I don't have any thoughts of killing myself. __1 I have thoughts of killing myself, but I would not carry them out. __2 I would like to kill myself. __3 I would kill myself if I had the chance	__0 I haven't lost much weight, if any, lately. __1 I have lost more than five pounds. __2 I have lost more than ten pounds. __3 I have lost more than fifteen pounds.
__0 I don't cry any more than usual. __1 I cry more now than I used to. __2 I cry all the time now. __3 I used to be able to cry, but now I can't cry even though I want to.	_0 I am no more worried about my health than usual. __1 I am worried about physical problems like aches, pains, upset stomach, or constipation. __2 I am very worried about physical problems and it's hard to think of much else. __3 I am so worried about my physical problems that I cannot think of anything else.
	__0 I have not noticed any recent change in my interest in sex. __1 I am less interested in sex than I used to be. __2 I have almost no interest in sex. __3 I have lost interest in sex completely.

Date:

Mental Health Provider Signature: ____