



**BEHAVIORAL
HEALTH**

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PRE-BARIATRIC SURGERY UPDATE QUESTIONNAIRE

INSTRUCTIONS

1. Your insurance provider has requested a current assessment of your mood and mental health status within 90 days of your surgery date. The behavioral health provider will review with you the findings from your initial workup, ask questions about how you are doing now, and provide an update to the surgeon.
2. You can return this paperwork by fax or in-person. You may also mail it to our hospital mailing address at Behavioral Health Dept, Family Health West, PO Box 130, Fruita, CO 81521. If you prefer, an electronic version on our website is also available.
3. Some of the questions are of a sensitive or personal nature. The provider and office staff will safeguard your privacy in compliance with current legal and ethical standards and will release information only to other professionals whom you have authorized and for whom you have signed consent. Please note that there are limitations to confidentiality when your safety or the safety of others may be compromised, and you can discuss any questions you might have about this with your provider.
4. Read each of the items carefully and answer honestly. If you are not certain of an answer, please give your best response. Be aware that your answers may be compared with information obtained from other medical records.
5. Some items may ask for information that you have already answered on this or on other medical forms or questionnaires. We apologize for the repetitiveness. Please answer these items anyway.
6. If an item seems unclear or if you have questions, you may make a notation on the questionnaire or ask the provider directly.
7. Thank you for your cooperation in filling out this form accurately and completely.

Pre-Surgical Psychological Update Information

Name _____ Date of Birth _____ Age _____ Today's Date _____
Residential Address _____ City _____ State _____

1. Since you were last here, have there been any changes in your living circumstances, work, family, or your relationship status? Yes No

If "yes," please describe: _____

2. What is your current weight? _____ lbs. Approximately how much weight have you lost _____ lbs. (or gained _____ lbs.), since you were last here?

3. Have you participated in a presurgical nutritional program supervised by a physician, nutritionist, or dietitian?
 Yes No

If "yes," how long was this? _____ months. Who supervised? _____
How many appointments did you have? _____

4. Since you were last here, have you read any books, watched instructional videos or programs or done other research on the subject of dieting, weight loss, or gastric surgery? Yes No

If "yes," please describe: _____

5. Since you were last here, have you attended any classes such as "Mindful Eating" or "Weight Management Solutions?"? Yes No

If "yes," please specify which classes: _____
On what dates did you attend? _____

6. Since you were last here, have you participated in any support groups? Yes No

If "yes," please specify which group(s): _____
On what dates did you attend? _____

7. Since you were last here, have you participated in any activity or exercise program, self-directed or supervised, such as walking, using home exercise equipment, enrolled in a gym or fitness center, worked with a personal trainer, used exercise videos, etc.? Yes No

If "yes," please describe: _____
When did you start exercising? _____ How often do you exercise? _____

8. Since you were last here, have you been under a doctor's care for any changes or problems in your health status?
 Yes No

If "yes," please describe: _____

9. Since you were last here, have there been any changes in your medication? Yes No

If "yes," please describe: _____

10. Since you were last here, have you been under the care of a psychologist, psychiatrist, individual counselor, pastoral counselor, marriage and family counselor, social worker, or other type of mental health therapist for mood, emotional, behavioral, or relationship problems? Yes No

If "yes," please describe: _____

11. Since you were last here, have there been any changes in your mood, personality, behavior, or emotional state, noticed by yourself, family members, or friends? Yes No

If "yes," please describe: _____

12. Since you were last here, have there been any changes in your use of alcohol, tobacco, caffeine, or recreational substances? Yes No

If "yes," please describe: _____

13. Please check any of the symptoms listed below that you have experienced **since you were here last time**:

- | | | |
|--|--|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Obsessive thoughts |
| <input type="checkbox"/> Discouragement | <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Compulsive behaviors |
| <input type="checkbox"/> Frustration | <input type="checkbox"/> Excessive energy | <input type="checkbox"/> General anxiety |
| <input type="checkbox"/> Persistent unhappiness | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Social anxiety |
| <input type="checkbox"/> Helplessness | <input type="checkbox"/> Impatience | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Irritability | <input type="checkbox"/> Flashbacks |
| <input type="checkbox"/> Low self-worth | <input type="checkbox"/> Agitation/anger | <input type="checkbox"/> Exaggerated startle |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Distractibility | <input type="checkbox"/> Feeling disconnected |
| <input type="checkbox"/> Loss of pleasure/interest | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Gambling problems |
| <input type="checkbox"/> Thoughts of death | <input type="checkbox"/> Risk taking | <input type="checkbox"/> Computer addiction |
| <input type="checkbox"/> Self-harmful behaviors | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Problems with pornography |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Confusion | <input type="checkbox"/> Eating problems |
| <input type="checkbox"/> Withdrawal/Isolation | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Alcohol/drug use |
| <input type="checkbox"/> Grief | <input type="checkbox"/> Judgment problems | <input type="checkbox"/> Suspicion/paranoia |
| <input type="checkbox"/> Guilt/shame | <input type="checkbox"/> Excessive worry | <input type="checkbox"/> Hearing voices |
| <input type="checkbox"/> Lack of motivation | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Visual hallucinations |
| <input type="checkbox"/> Feeling overwhelmed | <input type="checkbox"/> Phobias | <input type="checkbox"/> Other disturbing thoughts |

14. The term "mood" refers to one's overall sense of emotional well-being. On average, **over the last 6 months**, where would you rank your mood on a scale of 1 to 10 where 10 is best and 1 is worst? _____

Thank you for your patience in filling out this questionnaire! If you have answered all the questions, this is now complete.

Is there anything else you want us to know? If so, write some notes below.