FHW BEHAVIORAL HEALTH

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PRE-BARIATRIC SURGERY PSYCHOSOCIAL HISTORY QUESTIONNAIRE

INSTRUCTIONS

1. You have been referred to this office for a psychological evaluation regarding your application for a weight loss surgery, sometimes called gastric or bariatric surgery. The pre-bariatric evaluation is a psychological assessment, not treatment, and does not itself determine surgical eligibility. The evaluation provides clinical impressions and recommendations to inform the bariatric team's decision-making. The behavioral health provider does not approve or deny a patient for surgery, but instead contributes assessment findings to a multidisciplinary process. Recommendations may address readiness factors, risk considerations, and suggested interventions.

2. This new patient paperwork must be completed before an appointment can be scheduled. 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. This will include the referring bariatric program and will become part of your medical record. 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.

Section 1
Identifying Information

Patient Information

Patient's Legal Name: _____ **SSN:** _____

Patient's Preferred Name *(Nickname)* _____ **DOB:** _____

Legal Sex: ❑ Male ❑ Female **Sex Assigned at Birth:** ❑ Male ❑ Female ❑Choose not to disclose

Sexual Orientation: ❑ Straight/ Heterosexual ❑ Gay ❑ Lesbian ❑ Bisexual ❑ Choose not to disclose

❑ Other: _____

Gender Identity: ❑ Male ❑ Female ❑ Transgender Male ❑Transgender Female ❑ Choose not to disclose
❑ Other: _____

Address: _____ **Home Phone:** _____

City: _____ **Work Phone:** _____

State:_____ **Zip:** _____**Mobile:** _____

Email Address: _____ **❑ No Email ❑ Access to MyChart Portal**

Communication Preferences

I choose the following methods as my preferred communication methods for the options below:

To Do: *Tasks to help with your treatment plans and health goals*	[redacted]		❑ Text	❑ Email	[redacted]
FHW News and Information: *Information from your Healthcare Provider*	❑ Mail	❑ Phone Call	❑ Text	❑ Email	❑ MyChart
Account Updates: *Account management and account alerts*	[redacted]		❑ Text	❑ Email	[redacted]
Telehealth Visit Alerts/ Reminders:			❑ Text	❑ Email	
Appointment Notifications:	❑ Mail	❑ Phone Call	❑ Text	❑ Email	❑ MyChart
Billing Updates:	❑ Mail	[redacted]	❑ Text	❑ Email	[redacted]
Health Record Notifications/ Updates:	❑ Mail	❑ Phone Call	❑ Text	❑ Email	❑ MyChart
FHW Updates and Messages: *Receive updates from the FHW Organization*	❑ Mail	❑ Phone Call	❑ Text	❑ Email	❑ MyChart

Additional Demographics:

Marital Status: ❑ Single ❑ Significant Other ❑ Married ❑ Common Law ❑ Divorced ❑ Legally Separated ❑Widowed ❑ Patient Refused

Religion: ❑ Catholic ❑ Christian ❑ Church of Jesus Christ of Latter-Day Saints ❑ Orthodox Jew ❑ Jehovah's Witness ❑ None ❑Patient Refused ❑ Other: _____

Ethnicity: ❑Mexican, Mexican American, or Chicano/a ❑ Non-Hispanic ❑ Other Hispanic, Latino/a, or Spanish origin ❑ Patient Refused

Race: ❑ White or Caucasian ❑ Native American ❑ Alaskan Native American ❑ Black or African American ❑ Asian ❑ Patient Refused ❑Other: _____

Preferred Pharmacy:

❑ City Market Orchard Mesa	❑ Walgreens West Park Dr.	❑ Walmart Rimrock Ave
❑ City Market Clifton	❑ Walgreens Clifton	❑ Walmart North Ave
❑ City Market N 12th Street	❑Walgreens North Ave	❑ Walmart Warrior Way
❑ City Market 24 Road	❑ Walgreens Fruita	❑ Safeway Horizon Dr.
❑ City Market Fruita	❑ Target (CVS)Hwy 6 and 50	❑ Safeway F Rd

❑ Other: _____

Preferred Spoken Language: ❑ English ❑ Spanish ❑ Other: _____

Preferred Written Language: ❑ English ❑ Spanish ❑ Other: _____

Language and Interpreter Info: Need Interpreter? ❑ No ❑ Yes **Hard of Hearing?** ❑ No ❑ Yes

Low Vision? ❑ No ❑ Yes

Additional Patient Information:

Employment Status: ❑ Disabled ❑ Full Time ❑ Not Employed ❑ On Active Military Duty ❑ Part Time

❑ Previous Employer ❑ Retired ❑ Self Employed ❑ Student – Full Time ❑ Student – Part Time

Employer: _____ Employment Date: _____

Occupation: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Patient's Emergency Contact:

Name:_____ Relationship: _____

DOB:_____ Legal Guardian: ❑ Yes ❑ No Emergency Contact: ❑ Yes ❑ No

Address:_____

City: _____State: _____ Zip: _____

Preferred Phone: ❑ Home ❑ Mobile Number: _____

Preferred Written Language: _____Preferred Spoken Language: _____

Interpreter needed? ❑ Yes ❑ No Notify on Admission? ❑ Yes ❑ No

Authorized to receive letters about patient? ❑ Yes ❑ No

Authorized to have MyChart Proxy? ❑ Yes ❑ No

If you would like us to be able to speak to another party about your appointments and account, please list

Name:_____ Phone#: _____

Patient Care Team:

Primary Care Provider: _____

Office: _____

Receive Notifications about Admissions? ❑ Yes ❑ No

Receive Result Notifications? ❑ All Results ❑ Abnormal results only ❑ No results

Section 2
Eating, Weight, and Dietary History

The following items relate to the reason or reasons why you are seeking behavioral health support.

How tall are you? _____ feet _____in How much do you weigh now? _____lbs.

What is the most you have ever weighed (excluding pregnancy)? _____lbs. When? _____

What is your current Body Mass Index (BMI)? _____

At what age did you become heavy? _____ At what age ***do you think*** you became obese? _____

Indicate what factors you believe contribute to your being overweight.

□ Genetics (family history of obesity)
□ Metabolic (endocrine or hormonal problems)
□ Sedentary lifestyle / low physical activity
□ Chronic pain with physical limitations
□ Other medical problems
□ Family or cultural eating patterns
□ Emotional eating (food for comfort)
□ Overeating (problems with portion control)
□ Stress eating (nervous eating)
□ Grazing (snacking throughout the day)
□ Boredom eating
□ Impulse eating
□ Binge eating (large amounts all at once)
□ Sweet eating (candies, cookies, high sugar food)
□ Salty eating (chips, nuts, salty snacks)
□ High carb eating (breads, pasta)
□ Poor nutritional choices (e.g. fast food)
□ Soda / soft drinks / sugar sweetened drinks
□ Excessive use of alcohol
□ Poor body awareness

Who in your ***biological family*** has had weight problems?

□ Mother
□ Father
□ Brother(s)
□ Sister(s)
□ Maternal Grandmother
□ Maternal Grandfather
□ Maternal Aunt(s)
□ Maternal Uncle(s)
□ Paternal Grandmother
□ Paternal Grandfather
□ Paternal Aunt(s)
□ Paternal Uncle(s)

How often do you overeat (have difficulty trying to stop or control what you eat)?

❒ Never ❒1 or 2 times a week ❒ Several times a week ❒ Every day

Which of the following patterns or behaviors do you have?

□ Eating more rapidly than normal
□ Eating until uncomfortably full
□ Eating a lot when not physically hungry
□ Eating alone out of embarrassment
□ Feeling disgusted, depressed, or guilty after overeating

In general, how much does it upset you that you have trouble stopping or controlling how much you eat?

❒ Not at all ❒A little ❒ A lot ❒ Extremely

How important has your weight or shape been in how you feel about yourself as a person.

❒ Not at all ❒A little ❒ A lot ❒ Extremely

Since becoming heavy, *how much of the time* have you been trying to follow a diet, a weight-loss program, or using other strategies in order to lose weight or keep from regaining weight you had lost?

❒ Not at all ❒25% of the time ❒ 50% of the time ❒ 75% of the time ❒All the time

What diets, programs, or treatments have you attempted in order to lose weight? (Check all that apply)

DIETS

□ Atkins diet	□ South Beach diet	□ Calorie counting
□ Other low carb diet	□ Other low-fat diet	□ Physician monitored diet
□ Nutritionist monitored diet	□ Grapefruit diet	□ Cabbage soup diet
□ Body for life	□ Biggest Loser	□ Macrobiotic
□ The Zone	□ Paleo diet	□ eDiets
□ Vegetarian	□ Pescatarian	□ Mediterranean
□ Ketogenic	□ "Crash" dieting	□ Metabolic research

PROGRAMS/EXERCISE

□ Weight Watchers	□ TOPS	□ Over Eaters Anonymous
□ Curves	□ Nutrisystem	□ Herbalife
□ Metabolife	□ Medifast	□ Slim Fast
□ Richard Simmons	□ Jenny Craig	□ Fit for Life
□ Hypnosis	□ Juice Fasting	□ Self-directed exercise
□ Work with personal trainer	□ Walking	□ Running
□ Swimming	□ Cycling/Spinning	□ Joined a gym

MEDICATION/SUPPLEMENTS

□ Phen Fen	□ Phentermine	□ Dexatrim
□ Dexedrine/stimulants	□ Hydroxycut	□ Alli
□ Hoodia/hoodoba	□ Contrave	□ hCG
□ Orlistat (Xenical)	□ Lorcaserin (Belviq)	□ Saxenda
□ Qsymia	□ Drugs, cocaine or meth	□ Other
□ Ozempic	□ Wegovy (semaglutide)	□ Mounjaro
□ Zepbound (tirzepatide)	□ Trulicity	

How many times (approximately) have you lost 20 lbs. or more and then gained it all back? (Check one)

□ Never □ 1 or 2 times □ 3-5 times □ 5-10 times □ More than 10 times □ More than 20 times

What is the most weight you have ever lost by trying? _____lbs. When? _____
How?_____ How long did you keep the weight off?_____

Have you ever attempted to lose weight by any of the following?

□ Making yourself throw up □ Taking laxatives □ Taking diuretics (water pills)
□ Fasting/abstaining from eating □ Over exercising □ Over-using diet pills

How long have you been considering weight loss surgery? _____
What prompted you to look into surgery now? _____

Who recommended/suggested that you consider weight loss surgery?

□ Physician □ Therapist □ Spouse / partner □ Parent □ Other family member
□ Friend □ Employer □ Self

What type of gastric surgery do you feel might be best for you?

□ Roux-en-Y (gastric bypass) □ Duodenal switch
□ Sleeve gastrectomy □ Gastric (LAP) band

On a scale of 1 to 10, where is your current motivation for surgery?_____ Realistic long-term goal weight? _____

What other goals do you have for weight loss surgery? _____

What does your spouse/partner/significant other think of your having weight loss surgery?
_____

Who, besides health care professionals, do you count in your support network (people who will be there to help you follow your diet and lifestyle changes and to provide encouragement for you)?
_____

What have you done, so far, to prepare yourself for weight loss surgery?
□ Read book(s). Which books? _____
□ Watched video(s). What videos? _____
□ Done research on the internet.
□ Attended classes. What classes? _____
□ Attended a support group: What group? _____
□ Participated in a pre-surgical medically supervised nutritional plan. How many months? _____
□ Changed eating patterns. How? _____
□ Changed activity/exercise patterns. How? _____
□ Spoken to others who have had bariatric surgery. Who? _____
□ Other. Specify: _____

What do you see as your personal role or responsibility for achieving lasting success following weight loss surgery?_____
_____

Section 3
Mood, Emotional, or Behavioral Concerns

Please check any of the symptoms listed below that you have experienced in the ***last 6 months***:

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

Have you had problems with your sleep? ❒ Yes ❒ No If "Yes," indicate which:

❒ Sleeping more than normal ❒ Trouble falling asleep
❒ Trouble staying asleep ❒ Waking up early
❒ Sleep apnea ❒ Feeling unrefreshed in the morning
How long have these problems been going on? _____

Have you had problems with your energy during the day? ❒ Yes ❒ No If "Yes," indicate which:

❒ Fatigue ❒ Little or no energy
❒ More energy than usual ❒ Restlessness/agitation
How long have these problems been going on? _____

Have you had problems with your appetite or eating patterns? ❒ Yes ❒ No If "Yes," indicate which:

❒ Poor appetite ❒ Increased appetite
How long have these changes been going on? _____
How much weight have you: Gained? _____ or Lost? _____

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? _____

Which, if any, of the following have been affected by the above mood or emotional difficulties?

❒ Handling everyday tasks	❒ Self esteem	❒ Relationships	❒ Hygiene
❒ Work/school	❒ Housing	❒ Legal matters	❒ Finances
❒ Recreational activities	❒ Sexual activity	❒ Parenting	❒ Health

Have you ***ever*** had thoughts of, made statements about, threatened or attempted suicide? ❒ Yes ❒ No
If "Yes," please describe: _____

Have you ***ever*** engaged in self-harmful behavior (such as cutting or burning)? ❒ Yes ❒ No
If "Yes," please describe: _____

Have you ***ever*** had thoughts, made statements, or attempted to hurt someone else? ❒ Yes ❒ No
If "Yes," please describe:

_____

CURRENT STRESSORS

Please indicate any of the following that been causing problems with your mood or emotional adjustment ***in the last 6 months***:

❒ Relationship problems	❒ Family problems	❒ Legal problems
❒ Social problems	❒ Occupational/school problems	❒ Health problems

Have you experienced any significant losses or life changes ***in the last year (***e.g. death of a family member or friend, job change, financial setback, relationship break-up, move, health problems, injury, or traumatic event)? If yes, please describe:

_____

_____

SUPPORT PERSONS AND RESOURCES

Please indicate any of the people or resources available to support you:

❒ Spouse/partner	❒ Mother	❒ Father
❒ Other family members	❒ Friends	❒ Healthcare providers
❒ Support groups	❒ Church/faith	❒ Educational classes

Describe any coping skills or strategies you have learned from prior therapy, classes, self-help books, or other sources that are helping you now: _____

_____

What do you think are some of your top strengths? _____

_____

Section 4
Mental Health History

The following items pertain to mental health treatment you have received and mental health history for your family members.

MENTAL HEALTH PROVIDERS

Please list any other providers (prescribers, counselors/therapists, or psychologists) you are currently seeing or have previously seen. This would include individual, group, marriage or family counseling, as well as classes for domestic violence, anger management, or sexual offenses. Please list the most recent at the top.

Type of Treatment (e.g. medications, therapy)	Provider Name	Dates	Diagnosis/Reason

PSYCHIATRIC MEDICATIONS

Please list medications you are ***currently*** taking.

Meant to Treat	Name of Medication	Dosage and Frequency	Prescribed by Whom
Depression			
Anxiety			
Mood stability			
Attentional deficits			
Psychosis			

Please list medications you **previously** took and no longer are taking.

Meant to Treat	Name of Medication	Dosage and Frequency	Prescribed by Whom
Depression			
Anxiety			
Mood stability			
Attentional deficits			
Psychosis			

Are you allergic to any medications? _____

Have you ***ever*** had any mood or emotional problems for which you were not treated? ❒ Yes ❒ No
If "Yes," please explain: _____

Have you ***ever*** been hospitalized in a mental health or psychiatric facility? ❒ Yes ❒ No
If "Yes," when: _____
Reason(s) for hospitalization: _____

FAMILY HISTORY OF MENTAL HEALTH PROBLEMS

Please indicate family members (blood relatives only) who have been evaluated or treated for any of the following problems:

Problem	Family Members Affected
Hyperactivity/ADHD	
Depression	
Bipolar disorder	
Suicidal thoughts, attempts, or death	
Alcohol use disorder	
Drug use disorder	
Anxiety/panic disorder	
Obsessive-compulsive disorder	
Schizophrenia	
Criminal/legal convictions	
Dementia	
Developmental delay	

Section 5
Social and Developmental History

The following items pertain to key relationships, your experiences growing up, and your education.

FAMILY HISTORY

Where were you born? _____ Where were you mainly raised? _____
While growing up, where else did you live? _____
If you moved often while growing up, what were the reasons? _____
While you were growing up, what was your father's main occupation? _____
While you were growing up, what was your mother's main occupation? _____
Is your father still living? ❒ Yes ❒ No If "No," what was the cause of death? _____
Is your mother still living? ❒ Yes ❒ No If "No," what was the cause of death? _____

Did your parents separate or divorce? ❒ Yes ❒ No If "Yes," how old were you at the time?_____
If "Yes," who did you live with mostly? ❒ Mother ❒ Father
If "Yes," did mother remarry? ❒ Yes ❒ No Did father remarry? ❒ Yes ❒ No

Growing up, what was your relationship with your mother like? _____
Growing up, what was your relationship with your father like? _____
What was your relationship with your step-parent(s) like? _____
Number of "full" siblings: _____ Number of half siblings: _____ Number of step siblings: _____
What was your rank in birth order (oldest, next to youngest, 3rd of 5, etc.)? _____
What was growing up like for you? Please describe: _____
_____

While growing up, did you experience any of the following? (Check all that apply).

❒ Emotional abuse	❒ Parent alcohol abuse	❒ Poverty
❒ Sexual abuse	❒ Parent drug abuse	❒ Multiple family moves
❒ Physical abuse	❒ Parent illness	❒ Homelessness
❒ Parental neglect	❒ Childhood trauma	❒ Loss of a loved one
❒ Violence in the home	❒ Foster placement	❒ Teenage pregnancy

EDUCATION HISTORY

Did you graduate from high school? ❒ Yes ❒ No Approximate GPA (in high school) _____
If "No," what was the highest grade you completed? _____
If "No," did you finish a GED? ❒ Yes ❒ No At what age? _____
Any college classes, trade school, or certifications? ❒ Yes ❒ No In what field? _____

❒ Associate's Degree	Institution _____	Year_____	Major _____
❒ Bachelor's Degree	Institution _____	Year_____	Major _____
❒ Graduate Degree	Institution _____	Year_____	Major _____

Were you ever held back? ❒ Yes ❒ No Did you take special classes for learning problems? ❒ Yes ❒ No
Were you suspended or expelled? ❒ Yes ❒ No Take special classes for behavior problems? ❒ Yes ❒ No
Extracurricular activities (e.g. soccer, band, debate): _____
Are you currently attending school? ❒ Yes ❒ No If "Yes," where? _____
If "Yes," what is your field of study? _____

MILITARY HISTORY

Have you been or are you currently in the military? ❒ Yes ❒ No (If "No," skip the following questions):
Branch: _____ How long did you serve? _____ Were you overseas? ❒ Yes ❒ No
Were you involved in combat? ❒ Yes ❒ No If "Yes," briefly explain: _____
What was your job title or military occupation specialty (MOS)? _____
Date of Discharge: _____ Type of Discharge: _____ Rank at Discharge: _____

EMPLOYMENT HISTORY

What type of work have you done most of your adult life? _____
What other jobs have you held? _____
If employed, current employer: _____ Position: _____
Length of time in this position: _____ Job Duties: _____
Have you ever been disciplined or fired from a job for conduct problems? ❒ Yes❒ No If "Yes," explain:
_____

If not currently employed, are you any of the following? ❒ Retired ❒ Home by choice ❒ Disabled
If disabled, what is the reason for the disability: _____

Which of these benefits do you receive? ❒ SSDI ❒ SSI ❒ Food Stamps ❒ TANF ❒ WIC
❒ Workers Compensation ❒ None ❒ Other (please specify: _____)

MARITAL / RELATIONSHIP HISTORY AND CHILDREN

Have you ***ever*** experienced feeling unsafe (physically or emotionally) in a relationship with a romantic partner?
❒ Yes ❒ No If yes, how long ago? _____
Are you ***currently*** in a relationship? ❒ Yes ❒ No If yes, how long has the relationship lasted? _____
How is the relationship? _____
Have you been married or had a live-in relationship ***previously***? ❒ Yes ❒ No If "Yes," how many times?_____
Prior marriages/live-in relationships:

How long?	**Reason relationship ended:**
1st	
2nd	
3rd	

Please list any children, including your relationship with them (e.g. biological, step-child, foster, adopted, deceased).

First Name	**Relationship**	**Gender**	**Age**

Section 6
Medical History

The following items pertain to physical health conditions and medications you are taking.

Primary care provider: _____ Date of last physical/lab work: _____
Specialists you see (name/type): _____

Indicate which of the following medical conditions you have ***ever*** experienced:

❒Diabetes	❒Chronic back pain	❒Asthma	❒Meningitis
❒Autoimmune disease	❒Recurring headaches	❒COPD	❒Encephalitis
❒Acid reflux (GERD)	❒Fibromyalgia	❒Digestive problems	❒Brain injury
❒Sleep apnea	❒Thyroid problems	❒Rheumatoid arthritis	❒Bowel disease
❒High cholesterol	❒Liver problems	❒Osteoarthritis	❒Bladder disease
❒Heart disease	❒Kidney problems	❒Neurologic problems	❒Cancer
❒Hypertension	❒Circulatory problems	❒Stroke	❒Ulcers
❒Chronic fatigue	❒Blood disease	❒Seizure	
❒Chronic joint pain	❒Gallbladder disease	❒Neuropathy	

Indicate any health issues for which you are ***currently*** being followed or treated medically:

_____
_____

List ***current*** prescription medications:

Medication	Dosage	Frequency	Prescribed By

List any over-the-counter (OTC) medications/vitamins/supplements you regularly take:

_____

List any surgeries you have ever had:

_____
_____

Section 7
Alcohol and Substance Use History

ALCOHOL USE

The following items pertain to your experiences with alcohol and other drugs.

How often do you ***currently*** drink an alcoholic beverage?

❒ Never ❒ A few times a year ❒ 1 or 2 times a month ❒ 1 or 2 times a week
❒ Several times a week ❒ Every day

If you drink now or previously drank, how old were you when you began drinking? _____
How old were you when you started drinking more regularly? _____

If you drink, what type of beverage do you prefer (beer, wine, mixed drinks, etc.)? _____

How often will you have 5 or more alcoholic drinks on a single day?

❒ Never ❒ A few times a year ❒ 1 or 2 times a month ❒ 1 or 2 times a week
❒ Several times a week ❒ Every day

Has anything happened ***in the past year,*** as a result of drinking, that you regret? ❒ Yes ❒ No
If, "Yes," please explain: _____

Have you ***ever*** had blackouts, withdrawal symptoms, or health problems (e.g. enlarged liver, seizures) associated with drinking? ❒ Yes ❒ No
If "Yes," please describe: _____

Have you ***ever*** had legal, social, or work problems (e.g. arrest for DUI, missed work, gotten into fights or lost friends) because of drinking? ❒ Yes ❒ No:
If "Yes," please describe: _____

Has anyone ***ever*** suggested that you drink too much or that you ought to cut back? ❒ Yes ❒ No
If "Yes," please describe: _____

Have you ***ever*** been diagnosed or suspected of alcohol abuse or dependence? ❒ Yes ❒ No
If "Yes," please describe: _____

If you ***previously*** drank alcohol but stopped drinking, when did you stop? _____
Why did you stop drinking? _____

SMOKING AND NICOTINE PRODUCTS

Do you ***currently*** smoke cigarettes? ❒ Yes ❒ No
If "Yes," how often do you smoke? _____ How many cigarettes? _____

If you do not currently smoke, did you ***previously*** smoke cigarettes? ❒ Yes ❒ No
If "Yes," how often did you smoke? _____ How many cigarettes? _____
When did you stop? _____ Why did you stop? _____

Do you ***currently*** use smokeless tobacco (chew or snuff)? ❒ Yes ❒ No If "Yes," how often?

_____

Did you ***previously*** use smokeless tobacco? ❒ Yes ❒ No If "Yes," how often? _____
When did you stop? _____ Why did you stop? _____)_____

Do you use ***currently*** use nicotine in any other form (gum, patches, vapor pen, etc.)? ❒ Yes ❒ No
If "Yes," please describe: _____

OTHER SUBSTANCES

Do you ***currently*** use caffeine in any form (e.g., coffee, tea, Pepsi, Mountain Dew, etc.)? ❒ Yes ❒ No
If "Yes," what do you drink? _____ How much? _____ How often?
_____

Do you ***currently*** use marijuana in any form (e.g., edibles, CBD, smoking, etc.)? ❒ Yes ❒ No
If "Yes," what do you use? _____ How much? _____ How often? _____

If you ***previously*** used marijuana but quit, how much did you use? _____
When did you stop? _____ Why did you stop?
_____

Which of the following drugs do you ***currently*** use?

Drug	**Which Drugs?**	**Frequency of Use**
Stimulants (e.g. cocaine, methamphetamine)		
Hallucinogens (e.g. MDMA, LSD, psilocybin)		
Opioids (e.g. narcotic prescriptions, heroin)		
Inhalants (e.g. nitrous oxide)		
Other		

Which of the following drugs did you ***previously*** use?

Drug	**Which Drugs?**	**When Stopped & Why**
Stimulants (e.g. cocaine, methamphetamine)		
Hallucinogens (e.g. MDMA, LSD, psilocybin)		
Opioids (e.g. narcotic prescriptions, heroin)		
Inhalants (e.g. nitrous oxide)		
Other		

Has anyone ***ever*** suggested or accused you of abusing or being addicted to drugs? ❒ Yes ❒ No

If "Yes," please explain: _____

Do you ***currently*** use any of the following prescription medications?

❒ Narcotic pain medication	❒ Steroids	❒ Sedatives	❒ Sleep agents	❒ Anti-inflammatories

Has anyone ***ever*** suggested or accused you of misusing, abusing, or being addicted to pain medication, or of "medication (drug) seeking"? ❒ Yes ❒ No
If "Yes," please explain: _____

Please indicate any type of alcohol or substance abuse treatment you have ***ever*** had. This would include inpatient hospitalization, detox, outpatient individual or group therapy, drug or alcohol classes (court ordered or not), attendance at NA, AA or other support groups:

Type of treatment	When	Provider / Group	Duration	Reasons

Section 8
Legal History

Have you ***ever*** been arrested for a misdemeanor or felony? ❒ Yes ❒ No
If "Yes," how many times? _____

Have you ***ever*** been convicted of a misdemeanor or felony? ❒ Yes ❒ No
If "Yes," for what charge(s) or charges: _____

Have you ***ever*** been incarcerated? ❒ Yes ❒ No
If "Yes," how many times? _____ Where were you incarcerated? _____
How long were you incarcerated, all together? _____

Are you ***currently*** involved in any divorce or child custody proceedings? ❒ Yes ❒ No

Have you ***ever*** been involved in a lawsuit? ❒ Yes ❒ No
If "Yes," please explain: _____

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.