PINEYWOODS
PSYCHOLOGICAL SERVICES

Pre-Surgical Psychological For Bariatric Surgery Patients

Why do I have to have an evaluation?
Bariatric surgery is a life-altering event. While some aspects of the procedure are the same for everyone, each patient has a unique history and experience. Because of this, it is important to do a thorough individualized assessment to help each person meet the challenges of a changing relationship with food in the smoothest way possible. The purpose of the psychological evaluation is to support the long term success of your surgery and lifestyle changes.

What will happen during the evaluation?
Evaluations usually take only one session, lasting from 1-2 hours. First, you will meet with Dr. Kroll for an interview that will last about an hour. Second, you will complete a set of standard psychological tests. Please remember, there are no right answers or wrong answers to these tests. They are simply designed to provide as much information as possible about your attitudes, behaviors, emotions that may impact you during the surgical recovery. It is very important that you provide honest, candid answers, as this will ensure your medical team can best meet your needs. A report will be sent to your physician within a few days of your appointment. The evaluation meets standards set by the American Society for Bariatric Surgery and the Veteran's Health Care Administration MOVE program, as well as general ethical standards set by the American Psychological Association.

Confidentiality
Your privacy is protected under legal and ethical standards. Specifics of this will be discussed at your appointment, but in general, with only a few specific exceptions, everything you share will be kept to the strictest confidentiality and shared only with your immediate medical providers as is necessary to coordinate your care. Please do not hesitate to ask any questions you have about this issue.

Cost
The total cost for the evaluation is **$380**. Payment is due at the time of the appointment. For your convenience, all major credit cards are accepted. Dr. Kroll is an out-of-network provider for most insurance companies. You may be able to obtain reimbursement for a portion of the evaluation cost, depending on your policy. You can call your insurance provider and ask about your benefits for CPT codes 90791 and 96101, billing with the medical diagnosis code 278.01.

Patient Name: _____

In order to assist in the assessment process, please complete the following questionnaire prior to your appointment. Your answers are <u>confidential</u> and will only be shared with your medical providers. Please remember there are no right or wrong answers; the information you provide will be used to better understand you and will help your providers best meet your medical needs.

Name: _____

Home Address: _____ Zip:_____

Home Phone: _____ Work/Other Phone:_____

Date of Birth: _____/_____/_____

Age: _____ Race: _____ Gender: _____

Marital Status (circle) Single / Married / Divorced / Separated / Widow

Weight Loss History / Surgery Knowledge

What is your approximate current weight? _____ Height? _____Your Goal Weight after surgery? _____

How long have you been considering surgery? _____

When was your first appointment with the surgeon? _____

What / who made you interested in the surgery? _____

_____

What are your reasons for wanting the surgery? _____

_____

Have you attended any Surgical Support Groups? (circle) Yes No

Do you feel you adequately understand the surgical procedure? (circle) Yes No

If No, Questions:_____

_____

Do you feel you adequately understand the lifestyle changes required after surgery? (circle) Yes No

If No, Questions:_____

_____

How do your family / friends feel about you having the surgery? _____

_____

Have you ever taken laxatives or vomited on purpose because you ate too much food? No Yes

How much and how often do you exercise? _____

_____

Exercise limitations (describe): _____

_____

Patient Name: _____

Medical History (Please circle all that apply)

Joints	Short of Breath	High Blood Pressure	Cancer
High Cholesterol	Sleep Apnea	Arthritis	Diabetes
Heart Disease	Stroke	Head Injury	Emphysema
COPD	Asthma	Incontinence	Thyroid

Pain in: back hips knees feet other: _____

Swelling (where): _____

Past Surgeries: back knee gallbladder hysterectomy Other:_____

Other medical illnesses: _____

_____

Family Medical History (circle all that apply):

Diabetes	High	Blood Pressure	Heart problem	Obesity
Stroke	Cancer	Alcoholism/Drug abuse		

Other (list): _____

Family Psychiatric History (list): _____

_____

_____

Current Symptoms: (circle any in past 6 months)

Loss of Consciousness	Memory Difficulties	Blurred/Double Vision
Muscle Jerks or Twitches	Bowel or Bladder Problems	Speech Difficulties
Sleep Difficulties	Decreased Energy	Decreased Motivation
Decreased Happiness	Social Isolation	Frequent Headaches
Dizziness	History of Anorexia	Bulimia/vomiting/laxative Use
Seizures	Frequent Anxiety	Persistently Depressed Mood
Nightmares	Angry Outbursts	Mental Confusion
Driving Difficulties	Excessive Worry	Relationship Problems

For any circled above, please describe in detail, including frequency, severity, and treatment: _____

_____

_____

_____

_____

_____

Patient Name: _____

Medication	What's it for?	Medication	What's it for?

Your Psychiatric/Psychological History

Have you ever had any treatment for psychiatric/psychological difficulties (relationship counseling, psychological counseling, medicines for depression or anxiety, etc): (circle) **Yes** **No**

If yes, please describe below:_____

_____

_____

Substance Use

Are you currently drinking? No Yes

Average amount you regularly drink (ex: 1 drink/week, 5 drinks/day, etc): _____

What type of alcohol do you typically drink? (12 oz. can of beer, 6 oz cup of wine, shot of hard liquor):

_____

Have you ever been addicted to any drugs? No Yes (describe): _____

_____

Have you ever failed at attempts to quit alcohol or drugs? No Yes (describe): _____

_____

Have people ever said you should quit drinking or using drugs? No Yes (describe): _____

_____

Have alcohol or drugs ever caused social or job problems? No Yes (describe): _____

_____

Have you been involved in any treatment for drinking alcohol (including A.A.) or using drugs?

No Yes (describe): _____

_____

Patient Name: _____

Cigarette Smoking:

Are you currently smoking? No Yes

If you smoked previously, when did you stop? _____

Briefly describe attempts to quit smoking: _____

_____

Approximately how many years smoked in lifetime: _____

Average number of packs/day:_____

Educational/Occupational History:

High school degree? No Yes Years of college: _____

Currently working? No Yes, Where? _____

If not working, are you currently on short- or long-term disability benefits (i.e., SSDI, worker's compensation, etc)? No Yes

Social History

Have you ever been married? No Yes If yes, how many times? _____

Are you currently married? No Yes

How many kids do you have?_____

Who lives in your household?

Spouse (# years married: _____) Children (# _____) and ages:

Parents Other:

Do you have someone who can take care of you after you are released from the hospital? Yes No

Name: _____ Relation: _____

What do you like to do for fun? _____

_____

Do you feel you have enough social support? No Yes

Questions/Concerns?

_____

_____

_____

_____

If you have any specific questions or concerns that need to be addressed prior to your appointment, please call Dr. Kroll directly at 1 (888) 875-9902 ext 0. You may also visit our website at: *www.pineywoodspsychologicalservices.com*