Obesity2Balance
Bariatric Psychology for Living Well

Obesity2Balance

Bariatric Evaluation Questionnaire

Directions:

Please answer the questions below as openly, fully and honestly as possible. This information will help Dr. Cox or Dr. Ryland focus on the important issues in their interview with you.

Please complete the questionnaire privately and bring it with you to your interview.

We realize that much of this information is very personal, but it is necessary to help determine any needs you might have in psychological preparation for your surgery.

We can help you most if you are as open and honest as possible.

When a question lists possibilities like, "Yes No". Circle the one which applies.

If you have any questions, email DrBetsy@Obesity2Balance.com or DrGreg@GregCoxPhD.com or call (912) 264-1096

Today's Date:_____

Name:_____

Date of Birth:_____ Age:_____

Address _____

_____

Descriptive Information

(Please circle the word to indicate your answer.)

1. Gender: Male Female
2. Handedness: Right Left Ambidextrous
3. Race:_____

Personal History

1. Where were you born?_____
2. Any problems with your mother's pregnancy with you or with your birth?

   Yes No If yes, please explain:_____

   _____

   _____

3. How many brothers do you have? ___ How many sisters? ____
4. What number were you among your brothers and sisters? ____
5. For each of your brothers and sisters please list: age, education, occupation, any problems with drugs or alcohol, any problems with depression anxiety or other psychological concern:

Name	Age	Education	Occupation	Problems with Drugs or Alcohol?	Psychological Difficulties?

6. How did you and your brothers and sisters get along with each other as children?
   (Circle all that apply) Well Distant Fought Close
7. How do you get along with each other now?
   (Circle all that apply) Well Distant Fought Close

8. How often do you talk to your brothers and sisters?_____
9. Are your parents living: Mother: Yes No
   Father: Yes No
10. Are they currently married or were they married at the time of a parent's death?
    Yes No

Personal History (continued)

11. If your parents divorced and or remarried please list below your age at the time of each event: (for example - parents divorced when I was 8. Mother remarried when I was 12 and divorced again when I was 18. Father remarried when I was 14.)

12. How did your parents get along with each other when you were child?_____

13. Please give three words that would describe your Mom's personality:

_____
_____
_____

14. Please give three words that would describe your Dad's personality:

_____
_____
_____

15. Did either of your parents have trouble with drugs or alcohol?
Yes No If yes, please explain:_____

16. Did either of your parents have trouble with depression, anxiety or any psychological problems? Yes No If yes, please explain_____

17. If you had step-parents, how did you get along with them?_____

18. Was anyone involved in raising you besides parents and step-parents?
Yes No If yes, how did they treat you?_____

19. Were you ever mistreated as a child in any way; physically, sexually, emotionally or in any other way? Yes No

20. How would you describe your childhood? (circle any that apply)
Good Bad Easy Hard Confusing Fun
Complicated Relaxed Abusive Too Short Too Long

21. How old were you when you moved away from home? _____

22. What was the reason you moved?_____

Education

1. How far did you go in school?_____
2. What were your typical grades? A's B's C's D's
3. Were you held back in any grades? Yes No If yes, which grade(s)?_____
4. What subjects were easiest for you?_____
5. What subjects were hardest for you?_____
6. What was your style with friendships?
   Lots of friends A few close friends No friends
7. How would the kids you went to school with describe your personality?_____
   _____
8. What clubs, sports, band type activities were you involved in?_____
   _____
9. Do you enjoy reading? Yes No
10. What do you read when you get a chance?_____
    _____
11. Any favorite authors?_____

Vocational History

1. What is/was your work/job?_____
   _____
2. Where do you work?_____
   _____
3. How long have you worked there?_____
4. Do you like your work? Yes No
5. What do you like best about your work?_____
   _____
6. What do you like least about your work?_____
   _____
7. How do you get along with co-workers?_____
   _____
8. How do you get along with bosses?_____
   _____
9. What was the job you had for the longest period of time?_____
   _____
10. What was your favorite job?_____
    _____
11. Have you ever had problems on the job? Yes No If yes, please explain:_____
    _____
    _____

Marital and Family

1. What is your marital status?
   Single Married Divorced Widowed Living with Someone
2. If married or living with someone, how long have you been together?_____

3. What is your partner's name?_____
4. What does s/he do for a living?_____
5. How are you getting along?_____
_____
_____
6. What do you enjoy most about your partner?_____
_____
_____
7. What is your biggest frustration with your partner?_____
_____
_____
8. What do you think your partner enjoys most about you?_____
_____
_____
9. What do you suspect is your partner's biggest frustration with you?_____
_____
_____
10. Please describe your relationship history: (For example - married at 23 divorced at 27 lived with a guy from 30 to 34 married him at 34 divorced him at 38 single since but dating someone seriously for the last year.)_____
_____
_____
How does your partner feel about you having this surgery?_____
_____
_____
11. Have you ever been mistreated sexually in any way? Yes No
12. Have you ever had difficulties with sexual functioning? Yes No

13. Below please list your children's names:
For younger ones list age, grade, school (For example: Sally, 12, 6th, Central Primary)
For adult children list age, location, education, occupation, marital status and grandchildren (For example: Sam, 43, Seattle, B.S., Sales, married, two granddaughters - 6 &8 years old.)

Name	Age	Education	Occupation / School	Location	Marital Status	Grand-Children

Marital and Family (con't)

14. Who lives in the home with you now?_____
_____
15. Do you live in: House Mobile Home Apartment
16. Do you: Own Rent
17. How long have you lived in this location?_____

18. Are you a religious / spiritual person? Yes No
    If yes, are you affiliated with a religious group? Yes No
19. If so what group?_____
20. Is your faith helpful to you in dealing with life struggles? Yes No

Legal History

1. Have you ever been charged, convicted, sentenced, incarcerated, or put on probation for a crime? Yes No
    If yes, please describe:_____
_____
_____
_____

2. Have you ever sued or been sued by anyone? Yes No
    If yes, please describe:_____
_____
_____
_____

Medical History

1. Do you now or have you in the past suffered any of the following? (*Please check all that apply.)*

___High Blood Pressure ___Diabetes ___Stroke ____ Sleep Apnea
___Heart Disease ___Kidney Disease ___Lung Disease
___Cancer ___Liver Disease ___Pain Disorder
___Other (Please list)_____

___No significant medical history

2. Please list below any hospitalizations you've had listing dates time period and cause. (For example 6/89, overnight, broken arm):

Date	How Long?	Cause

Medical History (con't)

3. Please list below any surgeries you've had listing date, type of surgery and outcome. (For example 7/59, appendix out, wound infection took one month to heal):

Date	Type of Surgery	Outcome

5. If this weight loss process goes the way you want, what size will you be when your weight levels off?_____
6. How long have you been considering this surgery?_____
7. Where have you gotten information about it?_____
_____
8. Do you feel confident that you are making a well informed decision about this surgery?
Yes No
9. Do you have questions about the surgery that haven't been answered to your satisfaction?
Yes No
10. Please list below any serious injuries you've had listing date, type of injury and outcome. (For example 1/82, fell on ice - hit head - knocked out for 20 min.):

Date	Type of Injury and outcome

11. How is your vision? ___Fine ___OK with glasses/contacts ___Poor
12. How is your hearing? ___Fine ___OK with Aid ___Poor
13. Have you ever: (check all which apply
___been knocked unconscious ___had severe high fevers
___had convulsions / seizures ___unusual headaches
___weakness or fainting ___confusion
___had unusual hearing or vision disturbances
___None of the above.

Please explain any of the above:_____
_____

Do you smoke tobacco? Yes No
If so how much _____ Pks/Day
Did you ever smoke tobacco? Yes No
If so how much _____Pks/Day
If you have quit when did you quit?_____
What prompted you to quit?_____

Please list what medications you take -

PRESCRIBED FOR	**NAME OF MEDICATION**	**PRESCRIBED FOR**	**NAME OF MEDICATION**
High blood pressure		Heart medication	
High cholesterol ___		Depression (anti-depressants)	
Diabetes		Psychiatric	
Hormones		Other:	

_____

_____

Do you consistently take your medications as prescribed? Yes No

Weight / Diet History

1. How much do you weight now?_____ How tall are you?_____
2. What is the most you've ever weighed?_____ When was this?_____
3. What is the least you've weighed since you were 25 years of age?___
   When was this?_____
4. At what age did you first notice that you were overweight?_____
5. Please provide below your weight history to the best of your memory:

Age	6	10	15	20	30	40	50	60
Weight								

6. Were there life events related to sudden increases in weight? (For instance - puberty, child birth, loss of a loved one, job loss, injury, illness, either of yourself or a loved one) Yes No
If so please describe:_____

_____

_____

7. At what age did you first attempt diet control?_____

8. Please list below all major diets you've tried, describing what the diet was and the approximate date you tried it, how much you lost, whether you gained that weight back and how long it took to gain it back:

Name of Diet & Date	How much lost	Did you gain it back?	How long to gain weight back?

9. Have you ever taken prescription medication for weight loss? Yes No If yes, which medicines?_____
   Did you lose weight on the medicine? Yes No If yes, how much?___
10. Have you ever taken over-the-counter medication for weight loss? Yes No If yes, which medicines? _____
    Did you lose weight on the medicine? Yes No If yes, how much?___
11. If you gained that weight back, how long did it take?_____
12. Have you ever gone on eating binges when you ate abnormally large amounts of food over a short period of time? Yes No
13. During the binge did you feel a loss of control of your eating? Yes No
14. To prevent weight gain from the binge, would you sometimes:
    Force yourself to vomit? Yes No
    Fast afterward? Yes No
    Use laxatives or water pills? Yes No
    Exercise vigorously? Yes No

15. If you have ever binged, when was the most recent time?_____
16. If you have ever binged, how often has the binging happened?_____
17. Do you snack continuously (graze) through the day and/or night ? Yes No
18. What is the longest you have ever gone without eating?_____When was this?_____
19. Have you ever weighed less than what is average for your height? Yes No
20. Does your weight or the shape of your body have a big effect on your opinion of yourself? Yes No
21. If so please describe:_____
22. Do you perform regular exercise? Yes No
    What do you do for exercise?_____ How often?_____

Alcohol or Drug History

1. Do you drink alcohol? Yes No
2. How often? _____ How much typically?_____
3. How much alcohol is required to get you tipsy?_____
4. When did you last have that much?_____
5. How often do you have that much?_____
6. Have you ever had: (please check all which apply)
   - ___Family trouble because of drinking
   - ___Legal trouble because of drinking (DUI, public intoxication)
   - ___Job trouble because of drinking
   - ___Period of time you couldn't remember because of drinking
   - ___The "shakes" from drinking
   - ___Alcohol treatment (AA, inpatient)
   - ___No history of problems from alcohol
7. Do you or have you ever used illegal drugs? Yes No
8. Please check all used:

___Marijuana	___Cocaine	___Speed
___PCP	___LSD	___Injections
___Medication which was not yours		___Inhalants
___Other Illegal drugs		___No history of drug use

9. Have you ever had: (please check all which apply)
   - ___Family trouble because of drugs.
   - ___Legal trouble because of drugs
   - ___Job trouble because of drugs
   - ___Drug treatment (NA, inpatient)
   - ___No history of problems from illegal drugs

Alcohol or Drug History (con't)

10. Any family history of drug or alcohol abuse? Yes No
    Please describe:_____
_____
_____

Psychological History

1. Have you ever had any counseling or psychotherapy? Yes No

If yes, please list person who treated you, credentials, date, time period and purpose: (For example - Dr. Jones, psychologist, 6/02, six months, family problems):

Person who treated you	Credentials	Date	Time Period	Purpose

2. Any family history of psychological difficulties or treatment? Yes No
   If yes, please describe_____
3. Please rate the following as they would or would not apply to you:
   0 = Never
   1= Occasionally or Mild
   2= Regularly or Moderate
   3= Frequently or Severe

___blue mood ___tearfulness ___appetite change
___sleep change ___fidgetiness ___sluggishness
___fatigue ___loss of interest ___worthless feelings
___concentration problems ___thoughts of suicide

___difficulty breathing ___chest pain ___heart racing
___choking ___dizziness ___tingling hands/feet
___hot/cold flashes ___sweating ___faintness
___trembling/shaking ___fearfulness ___worry
___nightmares ___flashbacks

___hyperactivity ___fast speech ___racing thoughts
___distractibility ___impulsivity ___super good mood
___irritability ___long periods without need for sleep

___see things not there ___hear things not there
___unusual beliefs ___feel people are out to get me
___get lost in my own thoughts ___told I'm not like most people

___make careless mistakes ___difficulty paying attention
___difficulty listening ___trouble following instructions
___difficulty organizing ___lose things
___forgetful ___impatient
___interrupt conversation ___trouble staying on topic

Psychological History (continued)

4. What is your mood most days?_____
5. On a bad day are you more likely to be: Down Anxious Irritable
   How often do you have a bad day?_____
   How long does a bad mood last when you have one?_____
4. Have you ever injured yourself on purpose? Yes No
5. Have you ever tried to kill yourself? Yes No
6. Have you ever had serious thoughts of killing yourself? Yes No
7. Have you ever had serious thoughts of killing anyone? Yes No
8. What is the worst experience you've ever had?_____

Hobbies, Activities, Interests:

1. What are your favorite activities?_____
2. What activities does your weight prevent that you miss?_____
3. What activities are you looking forward to after losing your weight?
4. What do you think will be the most positive effect of your weight loss?_____
5. What is a goal you would set for yourself if you were thinner which doesn't seem possible now?_____

Any thing else you would like us to know?

Thank you for your time and attention.

Betsy Ryland, Ph.D. Psychologist
3226 F Hampton Ave
Brunswick, GA 31520
912-264-1096

Patient Financial Policy Information - Dr. Betsy Ryland - Psychologist

Patient Name:_____ Date of Birth: _____

Patient agrees to pay for all portions of services in full at the time services are provided by our office. Please read the Information and Payment Information sheet for further explanation.

You are required to present a valid insurance card and photo ID at every visit as needed throughout your care.

Commercial Carriers: We bill most insurance carriers for you if proper paperwork is provided to us. Any outstanding balances, co-payments and deductibles are due prior to checking in for your appointment. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it is less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, fees are due and payable in full from you. It is recommended you contact your insurance carrier to verify your coverage prior to your appointment.

Bariatric Evaluations: You are responsible for obtaining any prior authorizations from your insurance carrier for mental health bariatric services which are separate from medical authorization.

Medicare: Dr. Ryland is not a Medicare Provider. All services are provided for fee at time of service.

Worker's Compensation: If your visit is work-related we will need the case number and carrier name prior to your visit in order to bill the worker's compensation insurance company.

Appointment Cancellation Policy: Please call (912) 264-1096 to make changes in appointments or cancellations at least 24 business hours in advance. A charge will be made for unkept appointments not cancelled at **least 24 business hours in advance**. The number is (912) 264-1096 for appointment changes or cancellations. The fee for unkept or not cancelled therapy appointments Is $50.00 and for assessment unkept or not cancelled appointments is $150.00. Other fees may apply for other types of appointments. This fee is not covered by insurance.

We accept as methods of payment Cash, Personal Check, Visa, and MasterCard.

For returned checks we asses a $30.00 NSF charge, and report to the local district attorney's office checks that are not paid within 2 weeks of being returned to our office.

If not paid according to terms the patient understands that our office reports to an outside collection agency. In the event that your account is turned over for collections, patient agrees to pay all additional fees accessed in the collection of debt. These fees include collection agency fees and attorney fees.

The patient is ultimately responsible for all fees for services. I have read, understood and agreed to the above financial policy for payments of professional services.

I have received a copy of Information on Payment & Insurance and Information for Psychotherapy Appointments.

_____ _____
Patient Signature Date

Greg Cox, Ph.D.
Betsy Ryland, Ph.D.
3226 F Hampton Ave
Brunswick, GA 31520
912.264-1096

ADULT BARIATRIC EVALUATION INTAKE INFORMATION

Date:_____

BEST CONTACT PHONE NUMBER: _____

Patient Legal Name:_____ Birth date:_____
☐ Single ☐ Married ☐Divorced ☐ Widowed ☐ Female ☐ Male

Mailing Address:_____

City: _____ State: _____ Zip Code:_____

Phone: Home:_____ Work:_____ Cell:_____

Email Address:_____

Employed by:_____ ☐ Full Time ☐ Part Time

Emergency Contact:_____ Relationship to Patient:_____

Contact Phone: Home:_____ Work:_____ Cell:_____

Medical Insurance? ☐ Yes ☐ No

1. Primary Company & Address_____
   Behavioral Health phone number from back of insurance card: _____

   Policy Holder Name_____ SSN _____ DOB _____

   ID#_____ Group #_____

2. Secondary Company & Address _____
   Behavioral Health phone number from back of insurance card: _____

   Policy Holder Name_____ SSN _____ DOB _____

   ID#_____ Group #_____

I hereby authorize my insurance benefits to be paid directly to the psychologists listed above realizing that I am responsible to pay non-covered services and I hereby authorize release of pertinent information to insurance carriers, the staff of this office and my referral source. I also authorize Dr.'s Cox and Ryland to process my insurance claims electronically.

Patient Signature _____

Greg Cox, Ph.D.
Betsy Ryland, Ph.D.
3226 F Hampton Ave
Brunswick, GA 31520
912.264-1096

APPOINTMENT REMINDER CALLS

The office of Dr.'s Cox and Ryland can contact you a day or so in advance of your appointment if you wish.

Please check the box as it applies to you:

☐ **Do NOT remind me of appointments.**

☐ **Remind me of appointments by:**

- ☐ **Email address: _____**
- ☐ **Telephone: (_____) _____ - _____**
  - ☐ **Leave a message if answered by voicemail.**
  - ☐ **Leave a message if someone else answers the phone.**
  - ☐ **Do not leave a message**

Please inform the office if your contact information changes at 912-264-1096.

I understand I am responsible for keeping all scheduled appointments, unless I notify Dr.'s Cox and Ryland's office 24 hours (business hours) in advance of my appointment.

_____ _____

Name Date

Obesity2Balance
Bariatric Psychology for Living Well

Greg Cox, Ph.D.
Betsy Ryland, Ph.D.
Psychologists

BARIATRIC EVALUATIONS

CONSENT TO TREATMENT, RESEARCH AND TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you,_____ and Obesity2Balance LLC, members Greg Cox, Ph.D. and Betsy Ryland, Ph.D.

When we examine, diagnose, treat or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information to decide what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing for us to treat you and to let us use your information and send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share information. Please read this before you sign this Consent form. By signing this form you indicate that you understand that your referral is not based on the identified presence of a psychological disorder and this is a screening evaluation. You are agreeing to take financial responsibility for your bariatric evaluation.

If you do not sign this consent form agreeing for us to treat you and what is in our Notice of Privacy Practices, we cannot treat you.

In the future we may change how we use and share information, and so, may change our Notice of Privacy Practices. If we do so, you will get a copy from us or you can call us at 912-264-1096.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wishes.

In particular you are agreeing for us to release information to and receive information from your doctor and his staff at Georgia Coast Surgical and your insurance company(ies). You also are agreeing for us to release information to and receive information from _____
_____
_____.

In addition, you are agreeing that your information may be used in research or presentations. The purpose of the research will be to gain knowledge about psychological issues related to bariatric patients. No additional action on your part will be required. We will, from time to time, gather information from patients we have assessed and report that information as part of our research or

presentations. Your identity will never be attached to any of the information of yours we use in research or presentations. Others who have bariatric interventions in the future may benefit from such information gathering. If you have questions you may contact Betsy Ryland, Ph.D. 912-264-1096. Your participation in research is voluntary and will not affect you receiving any services from us. You may choose not to participate in research with no loss of benefits to which you would otherwise be entitled. Simply tell us that you do not want to be part of the research and your information will not be included in this part of our work.

If either you or we want to use or disclose (send, share, release) your information for any other purposes, we will discuss this with you and ask you to sign a Consent to Release of Information to allow this.

Of course we will keep your health information private but there are some times when the laws require us to use or share it such as:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization that is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires to do so.
4. For Workers Compensation and similar benefit programs.

There are some other situations like these which don't happen very often. They are described in the longer version.

After you have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that. This consent is in effect for 12 months.

_____ _____

Signature of Client Date

_____

Printed Name of Client

Greg Cox, Ph.D.
Betsy Ryland, Ph.D.
3226 F Hampton Avenue
Brunswick, Georgia 31520
Telephone (912) 264-1096
Fax (877) 288-1172

ACKNOWLEDGMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1 Provided and coordinate my treatment among a number of health care providers who may be involved in that treatment directly or indirectly

2 Obtain payment from third-party payer(s) for my health care services.

3 Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my medical provider/psychologist's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my medical provider/psychologist has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

For Office Use Only:

We were unable to obtain the patient's written acknowledgment of our Notice of Privacy Practices due to the following reason:

☐ The patient refused to sign
☐ Communication barriers
☐ Emergency situation
☐ Other