Williams Bariatric Questionnaire

Instructions: Although this form is quite lengthy, it is *very* important. Please circle the appropriate answers and explain where indicated.

Briefly list your prior diet attempts including approximate dates and name or type of diet:_____
_____
_____
_____

1. Do you have a history of losing greater than 50 pounds or a total body fat of less than 6%? Yes no
2. How long would you consider yourself as being overweight?_____ years
3. How long would you consider yourself as being seriously overweight?_____ years
4. What is your current weight?_____ height?_____ body mass index?_____
5. Do you often tend to eat until you're too full? Yes No
6. Do you tend to eat more when you're either sad or happy? Yes no
7. Do you overeat after dieting awhile because you feel starved? Yes no
8. Is it hard for you to tell when you're full? Yes no
9. Do you have a history of binging or purging? Yes no
10. Do you tend to overeat, "just because it's there?" Yes no
11. Do you use food to comfort yourself? Yes no
12. Do you use food to control your moods? Yes no
13. Do you tend to eat out of boredom? Yes no
14. Have you ever been diagnosed with Anorexia or Bulimia? Yes no

15. Do you tend to ask yourself, "Why am I eating this?" Yes no

16. How long would you consider yourself as being overweight? _____ years.

17. How long would you consider yourself as being seriously overweight (morbidly Obese)? _____ years.

18. Do you eat more food after 7 PM than before 7 PM? Yes no

19. Do you have problems falling/staying asleep in excess of four times per week? Yes no

20. Are you currently participating in a regular exercise program? Yes no

21. Do you have a history of participating in any aerobic exercise programs? Yes no

22. Do you have a plan of physical activity post surgery? Yes no
explain:_____

23. Is there a history of substance abuse (aside from food) with or without treatment? Yes no
explain:_____

24. Do you smoke marijuana or have a medical marijuana card in your name? Yes no

25. Your current average intake of alcohol over the past year is _____ alcoholic beverages per: Week / month / year.

26. Over the past 30 days, how many days have you had an alcoholic beverage on?_____ days

27. Over the past year, I have used the following recreational drugs:_____

28. Please list your currently prescribed medications:_____

29. Do you smoke cigarettes or chew tobacco? Yes no If yes, explain amounts and frequency:_____

30. Do you tend to be impulsive in your food choices? Yes no

31. Are you impulsive in other areas of your life (gambling, shopping, relationships)? Yes no

    explain:_____

    _____

    _____

32. Do you tend to feel that you have to eat even when you're not hungry? Yes no

33. Do you follow certain rituals regarding the time or type of food eaten during the day or weekends? Yes no

34. Do you follow your physicians recommendations regarding diet or exercise? Yes no

35. What percent of the time do you follow your physicians recommendations regarding diet or exercise? 10 20 30 40 50 60 70 80 90 100 percent of the time

36. Have you had any interactions with the legal system including: civil or criminal actions or litigations, arrests, lawsuits or been sued, bankruptcies past or present, or any pending legal matters? YES NO

    Explain:_____

    _____

    _____

37. Do you have a vision or hearing impairment? Yes no

    explain:_____

    _____

    _____

38. Can you read on at least a fourth grade reading level? Yes no

39. Are you your own legal guardian? Yes no

40. Do you have any history of participation in special education programming? Yes no

    explain:_____

    _____

    _____

41. Do you have any impairments of memory or thinking abilities? Yes no

42. Have you ever been found to be legally incompetent or had a Guardian appointed to represent you? Yes no

    explain:_____

    _____

    _____

43. Which bariatric surgery are you currently seeking? _____

44. Briefly describe your understanding of what you believe this surgery involves:_____

45. What are the possible risks and complications involved with this surgery:_____

46. Why have you chosen this particular bariatric surgery?_____

47. Why have you chosen to seek bariatric surgery at this point in your life?_____

48. What is your understanding of your responsibilities post surgically?_____

49. What sources of information have you accessed to learn about this particular bariatric surgery?_____

50. What sources of information do you plan to use after your bariatric surgery?_____

51. Do you currently experience stress, anxiety, frustration, despair, tension, or boredom?

52. What coping strategies do you use to address these emotions?_____

53. Do you experience stress from even positive events such as promotions, social events, and vacations? Yes no

54. What coping strategies do you use to address these stressors?_____

_____

_____

55. Do you ever experience significant mood variability without any obvious cause? Yes no

56. Do you ever feel that you're living your life from one crisis to the next? Yes no

57. Do you experience difficulty setting limits with others in your life? Yes no

58. Have you or are you experiencing discrimination and ridicule because of your weight? Yes no

59. What effect has this ridicule had on your life?_____

_____

_____

60. How have you attempted to address this ridicule?_____

_____

_____

61. How demoralized are you about your prior failed dieting attempts?_____

_____

_____

62. Do you view your weight control difficulties as indicating that you are defective, damaged, or a "behavior problem"? Yes no

63. Has your morbid obesity caused you to overcompensate by becoming a caretaker, nurturer, or comedian? Yes no
explain:_____

_____

_____

64. Do you sometimes compromise your self-esteem and self-worth in order to establish or maintain relationships? Yes no
explain:_____

_____

_____

65. Do others ever recognize this tendency in you? Yes no

66. Have you ever asked for help to address this issue? Yes no

67. Do you have a history of, received treatment for, or any prior diagnosis of:

    bipolar or manic-depressive disorder yes no

    severe depression yes no

    obsessive-compulsive disorder yes no

    impulse control disorder yes no

    addictive behaviors yes no

    schizophrenia or psychosis yes no

    borderline personality disorder yes no

    Explain any of the above marked as yes:_____

    _____

    _____

If you endorsed a prior history or diagnosis of bipolar or manic-depressive disorder please list the number and dates of most recent manic episodes:_____

_____

_____

68. Do you have a history of any suicidal thoughts, or suicide attempts? Yes no If yes, explain including dates and method of self harm:_____

    _____

    _____

69. Do you have a history of participating in outpatient mental health services including individual therapy, counseling, or psychiatric consultation? Yes no If yes, explain including dates seen, number of sessions, and reasons for participating in therapy services:_____

    _____

    _____

70. Have you ever been hospitalized for mental health or psychiatric reasons? Yes no If yes, explain including dates of hospitalization, location, and reason for hospitalization:_____

71. Have you ever been found to be disabled due to a mental health or psychiatric issue or diagnosis? Yes no If yes, explain including reason for finding of disability and date at which you were found to be disabled:

72. Have you ever participated in psychological testing or assessment in the past? If so, please list dates, reasons, and the name(s) of the psychologist(s).

73. Do you feel that you are emotionally stable enough to manage the postsurgical responsibilities of bariatric surgery? Yes no

74. Do you feel that you have been adequately informed of the risks for psychiatric episodes or emotional crises post surgery? Yes no

75. Do you have a mental health action plan in place as a precautionary measure for any postsurgical emotional adjustment issues? Yes no If yes, please explain your plan:

76. Have you experienced a history of prior trauma, abuse, or neglect? Yes no If yes, explain:

77. What steps have you taken to address the issues surrounding this prior history? Yes no NA

78. Is it difficult for you to develop attachments to people? Yes no

79. While growing up, did you experience any difficulties reaching developmental milestones such as walking, speaking, or achieving academic success? Yes no If yes, explain:

80. Do you have a history of recent or more lifelong stressors? Yes no If yes, explain:_____

_____

_____

81. Do you have a group of friends that you socialize with on a regular basis? Yes no

82. Do you feel supported in your decisions by your group of friends? Yes no

83. Are you satisfied with your current romantic or emotional relationships? Yes no

84. Are you willing and able to participate in both pre-surgical and postsurgical support groups? Yes no

85. What is currently motivating you to seek surgery at this time?_____

_____

_____

86. Are there issues other than health which are also motivating you to seek surgery? (E.G. employment, physical appearance, etc.)

_____

_____

_____

87. Are you willing to commit to actively and permanently following the postsurgical guidelines for health and success? Yes no

88. Do you believe that weight loss surgery or weight loss will make you a happier person? Yes no

89. Do you believe that weight loss surgery or weight loss will lead to a happier life? Yes no

90. From an emotional or personality perspective, why do you believe you've had difficulty losing weight or keeping weight off?_____

_____

_____

91. Have you ever experienced any significant emotional reactions to a surgical procedures in the past? Yes no

92. Again, from an emotional or personality perspective tell me why you believe your prior attempts at weight loss failed._____

_____

_____

93. If you do not qualify for weight loss surgery, what is your plan to better manage your weight?_____

_____

_____

_____ _____ _____

Print Name ***Signature*** ***Date***

HURLEY MENTAL HEALTH ASSOCIATES
ADULT QUESTIONNAIRE

If you need help reading or writing, take this form to the front desk and they will arrange for someone to help you. It is very important that your therapist understand your needs. We are aware that this is sensitive information and assure you that all information is confidential. Please answer the questions as honestly as you can. If a question doesn't apply, write "NA". If you don't know an answer, write "unknown". Your therapist will review this questionaire with you.

*Name:*_____ *Age:*_____ *Sex:*_____

COMMENTS
(Therapist only)

What problems are you needing help with today? _____

_____

_____

What changes do you hope for as a result of treatment? _____

_____

What are your strengths? _____

_____

What might get in the way of you meeting your goals? _____

_____

Have you ever been involved in therapy before? Yes No
*If so please tell us when and where.*_____

_____

RELATIONSHIPS

Name	*Age*	*Living*	*Date Deceased*
		Yes/ No	
Father			
		Yes/No	
Mother			
		Yes/No	
Step Father			
		Yes/No	
Step Mother			

Are (or were) your parents: Married Separated Divorced Never Married
What is/was communication like with your parents? Excellent Good Fair Poor
Please list brothers, sisters, stepbrothers, and stepsisters:

Name	*Age*	*Relationship*

What were your family relationships like? Cooperative Argumentative Distant Close

Have you ever witnessed or experienced abuse? (emotional, physical, or sexual)? Yes No

*If yes please explain:*_____

_____

_____

What limitations do you see in your family? _____

_____

Can you share personal problems with anyone in your family of origin? Yes No
If yes, with whom? _____
Are members of your current family supportive of you getting treatment? Yes No
If yes, whom? _____

Has anyone in your family experienced the following? (Please check)

COMMENTS
(Therapist only)

____*Emotional Problems* ____*Depression*
____*Anxiety* ____*Anger Problems*
____*Suicide Attempts* ____*Gambling Problems*
____*Relationship Problems* ____*Abuse Problems*
____*Alcohol/Drug Problems*

Did anyone in your family receive treatment for any of the above problems? Yes No
If yes, where and when? _____

Who are you living with now? _____

List marriages and or significant relationships you have had.

Name	*Married*	*Living Together*	*Boy/Girlfriend*	*How Long*
_____	*Yes/No*	*Yes/No*	*Yes/No*	_____
_____	*Yes/No*	*Yes/No*	*Yes/No*	_____
_____	*Yes/No*	*Yes/No*	*Yes/No*	_____

Please list your children and indicate if they are your natural, adopted, or step child.

Name	*Age*	*Natural*	*Adopted*	*Step*
_____	____	*Yes/No*	*Yes/No*	*Yes/No*
_____	____	*Yes/No*	*Yes/No*	*Yes/No*
_____	____	*Yes/No*	*Yes/No*	*Yes/No*

Are your children experiencing any emotional or alcohol or drug problems? Yes No
If yes, what are they, and are they getting help? _____
_____

Have you lost anyone close to you through death or separation? Yes No
If yes, please describe what happened and the effect this is having on you now.
_____
_____

Whom in your family do you feel closest to? _____

RECREATION *(please check)*

____*Sports* ____*Clubs/Groups*
____*Hunt Fish Camp* ____*Exercise Regularly*
____*Watch TV* ____*Electronic Games*
____*Internet/Computer* ____*Read*

Are you frequently bored? Yes No
Please explain: _____
_____
Has your use of free time recently changed? Yes No
Please explain: _____
_____
Are drugs/alcohol often involved in your recreational or hobby activities? Yes No

SEXUALITY *(do you consider yourself)*

COMMENTS *(Therapist only)*

Heterosexual (opposite sex) Gay/Lesbian (same sex) Bi-sexual (both sexes) Unsure
*At what age was your first sexual experience:*_____
Is there any area of your sexuality with which you are not comfortable? Yes No
*Please describe:*_____
_____
Have you ever considered that some experiences meant you were sexually abused? Yes No
Please check all that apply:

_____*Sexually active now*
_____*Sexually active in the past*
_____*Use birth control*
_____*Concerned about sexually transmitted disease*
_____*Have had unprotected sex*
_____*Have unanswered questions about sex.*
_____*Experienced sexually transmitted disease*

*Please describe any other sexual concerns:*_____

LEGAL

Have you had any arrests, convictions, misdemeanors, felonies, and parole/probation? violations or incarcerations as either a youth or an adult? Yes No
*If yes, please explain:*_____
_____
What is your current legal status?

_____*No problems* _____*Problems* _____*On tether*
_____*License suspended* _____*License revoked* _____*Awaiting trial*
_____*On probation/parole*

*Name and phone number of Parole/Probation Officer*_____

VOCATIONAL HISTORY

Are you currently in school? Yes No
*What was the last grade you completed in school?*_____
*Do you have any current educational goals?*_____
Did you participate in extracurricular activities such as sports or choir? Yes No
*Please list:*_____
Did you get along with your teachers and classmates? Yes No
Do you feel you have a learning problem? Yes No
Did you ever repeat a grade? Yes No
What were your grades like? Above Average Average Below Average
What was your attendance like? Never absent Occasionally Absent Frequently Absent
*Please describe additional training you've had:*_____
_____
Do you have a job now? Yes No Full-time Part-time

Jobs held in the last five years	*Time at each:*
_____	_____
_____	_____
_____	_____

What is you job attendance like? Above Average Average Below Average

*What do you like most about your job?*_____

*What do you like least?*_____

Is there another occupation you would prefer? Yes No
If so, what? _____

COMMENTS
(Therapist only)

Are your co-workers supportive of your getting help? Yes No

*If you are not working, but would like to be, what are your plans to get a job?*_____
_____

*Describe any current job or school problems:*_____
_____

Are you experiencing any financial problems? Yes No

Have you had military service experience? Yes No
Have you completed combat duty? Yes No
*Branch of service:*_____*Years of Service*_____
*Reason for separation?*_____

PEER RELATIONSHIPS *(which best describes your relationships)*

_____*Don't have any*
_____*Legal problems*
_____*Gambling centered*
_____*Athletic*
_____*Alcohol/drug-centered*
_____*Caring*
_____*Spiritual*
_____*Unpopular*
_____*Supportive*
_____*Emotional problems*
_____*Temper problems*
_____*Followers*
_____*Angry with me*
_____*Problematic*
_____*Popular*

*Other information about friends that you think is important?*_____
_____
Please list first names of a few of the friends who are most important to you:

Name	*Length of time known*
_____	_____
_____	_____
_____	_____

Do you talk about problems with your friends? Yes No
*Who do you trust most in your life right now?*_____
*Who in your life might be available to support you in treatment?*_____

DEVELOPMENTAL
As a youth did you experience any of the following?

Problem	*Age*	*Problem*	*Age*
_____*Serious accidents*	_____	_____*Hospitalizations*	_____
_____*Trouble with police*	_____	_____*Shyness*	_____
_____*Head injury*	_____	_____*Suicidal thoughts*	_____
_____*Running away*	_____	_____*Witnessed abuse*	_____
_____*Growth concerns*	_____	_____*Violence problems*	_____
_____*Behavior problems*	_____	_____*Pregnancy(s)*	_____
_____*Abortion(s)*	_____	_____*Sleeping problems*	_____
_____*Fear Problems*	_____	_____*Hearing problems*	_____
_____*Stuttering*	_____	_____*Emotional abuse*	_____
_____*Eating problem*	_____	_____*Speech problems*	_____
_____*Sexual abuse*	_____	_____*Suicide attempts*	_____
_____*Physical abuse*	_____	_____*Visual problems*	_____
_____*Depression*	_____	_____*Gang involvement*	_____
_____*Self esteem problems*	_____	_____*Gambling problems*	_____
_____*Cult/Satanic experience*	_____		

Are you aware of any major difficulties at the time of your birth or early infancy?
Yes No

COMMENTS
(Therapist only)

As a youth did you belong to any formal or informal groups? Yes No

*Describe:*_____
_____
Who or what has been most influential in your life? _____
_____

SPIRITUAL

_____*I believe in God/Higher power* _____*I don't believe in God/Higher power*
_____*I attend church/temple/mosque* _____*I don't attend church/temple/mosque*

*What values and/or spiritual beliefs are important to you?*_____
_____

MORE ABOUT YOU

*How do you feel most of the time?*_____

*When I feel mad I....*_____

*When I feel sad I....*_____

*When I feel glad I..*_____

*When I feel afraid I...*_____

*How have you been affected positively or negatively by your race, nationality, cultural? background?*_____
_____
_____

Have you ever attended self-help or support groups? Yes No
*Please explain:*_____
_____
_____
_____

*Is there anything else you would like your therapist to know about you?*_____
_____
_____

Thank you*.....*

_____ _____
Client's Signature *Date*

Revised 11-13-06

HURLEY MENTAL HEALTH ASSOCIATES
HEALTH QUESTIONAIRE

*PATIENT NAME (Print Only)*_____

1. *Do you have any medical symptoms at the time of this interview or persistent chronic or acute symptoms, which have lasted for more than a week such as pain, physical complaints, etc?*
   *Yes_____ No_____ Specify*_____

2. *Please indicate any physical disabilities, limitations, or ailments for which you have been treated:*
   _____
   _____

3. *Do you have a history of intravenous drug use, unconsciousness, hepatitis, or DT'S?*
   *Yes _____No _____ Specify*_____

4. *Do you have communicable disease (including any sexually transmitted diseases)?*
   *Yes_____ No_____ Specify*_____

5. *When were you last treated by a physician?* _____
   For what? _____

6. *When and where was your last physical?* _____

7. *Have you ever had surgery Yes ____ No _____ For what?* _____
   _____
   _____

8. *Do you smoke cigarettes? Yes_____ No_____*
   If yes, how many per day or per week? _____

9. *Do you drink alcoholic beverages? Yes_____ No_____*
   If yes, how much and how often? _____

10. *Do you drink caffeinated beverages (coffee, tea, colas, Mt. Dew, etc..)?*
    Yes_____ No_____ If yes, how much per day? _____

10. *Have you ever been in treatment at a detox or residential substance abuse or psychiatric program?*
    *Yes_____ No_____ Date Last Attended:*_____

*COMMENTS*_____
_____

Have you ever been in counseling or therapy before? Yes_____ No_____,
If so please explain:

_____
_____
_____
_____

(over)

Briefly describe your reason for seeking help _____

_____

_____

Please give any additional information that may be of any help to us:

_____

_____

_____

_____

Please circle any of the following problems, which pertain to you:

Nervousness	*Depression*	*Fears*
Shyness	*Sexual Problem*	*Suicidal Thoughts*
Separation	*Divorce*	*Finances*
Drug Abuse	*Alcohol Use*	*Unhappiness*
Anger	*Self Control*	*Friends*
Sleep	*Stress*	*Work*
Relaxation	*Headaches*	*Tiredness*
Legal Matters	*Memory*	*Ambition*
Energy	*Insomnia*	*Loneliness*
Decision Making	*Concentration*	*Thoughts*
Education	*Career Choices*	*Health Problems*
Temper	*Nightmares*	*Marriage*
Children	*Appetite*	*Stomach Trouble*
Bowel Trouble	*Pain*	

*CLIENT SIGNATURE*_____*DATE*_____

Revised 7-16-12

HURLEY One Hurley Plaza
FORM
MEDICAL CENTER Flint, Michigan 48503-5993

AMBULATORY MEDICATION RECONCILIATION

ALLERGIES: _____ Date/Initials_____ _____
Date/Initials_____

_____ Date/Initials_____ _____ Date/Initials_____
_____ Date/Initials_____ _____ Date/Initials_____

Drug Name (include dose, route, frequency)	Date Reviewed/ Initials	Date Reviewed/ Initials	Date Reviewed/ Initials	Date Reviewed/ Initials	Date Reviewed/ Initials

KEY:
Initials:_____ Name:_____ Clinic:_____ Initials:_____ Name:_____ Clinic:_____
Initials:_____ Name:_____ Clinic:_____ Initials:_____ Name:_____ Clinic:_____
Initials:_____ Name:_____ Clinic:_____ Initials:_____ Name:_____ Clinic:_____

Patient Label	**25** Ambulatory Medication Reconciliation Form Revised: August 29, 2006 *002125*

HURLEY MENTAL HEALTH ASSOCIATES
Authorization for Release of Information
1125 S. Linden Road, Suite 210
Flint, Michigan 48532

Patient Name: _____Date of Birth: _____ SS: _____
Address: _____City: _____ Zip: _____

I authorize the use or disclosure of the above named individual's health information from ***HURLEY MENTAL HEALTH ASSOCIATES*** *as described below.*
The type and amount of information to be used or disclosed is as follows:

Exchange of information between the Hurley Bariatric Center and Hurley Mental Health Associates, including psychological testing results and/or any follow up recommendations.

1. *This information pertains to the health care services that were provided to:*
   Name of Patient: _____

2. *This information may be disclosed to, and used by, the following individual or organization(s):*
   Name: ***HURLEY BARIATRIC CENTER 2700 Robert T. Longway Blvd, Suite H, Flint, MI 48503***
   For the following purpose: (the individual authorizing release of information may write "at the request of the individual" if the individual elects not to provide a statement of purpose.

   Determination of appropriateness for bariatric surgery and/or assistance with the preparation for and/or follow up after Bariatric surgery.

3. *I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services, and treatment for alcohol and drug abuse.*

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke the authorization, I must do so in writing and present my written revocation to the individual in charge of my treatment. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

_____
If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

6. I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to ensure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules.

_____ _____
Date *Patient's Signature*

_____ _____
Witness Signature *Parent or Guardian's Signature if Required*
Revised 6-15-06