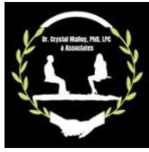

Dr. Crystal Malloy, PhD, LPC & Associates
Progressive & Innovative Counseling Service
5618 White Bluff Road, Suite B & C
Savannah, GA 31405

Phone (912) 231-7031
Fax (912) 250-6025

Bariatric Assessment Intake Form

Date: ____________________

Name: ____SSN last 4: ____________ Date of Birth: ____________

Age: _____ Gender: ____ Race/Ethnicity: ________________ Married ____ Single ____ Divorced ___ Widowed ____

Address: ____ Phone: ______________________________

City: ____ State: _______________ Zip: _______________________

Email: ____

Employer: ____ Job Title ____

Person Responsible for the Bill (if different from above): ____

Name: ____ SSN #: ________________________________

Date of Birth: _________________________ Age: __________ Gender: ___________ Race: ______________________________

Address: ____ Home Phone: __________________________

City: ____ State: _______________ Zip: ______________________________

Employer: ____ Work #: ____________________________________

Emergency Contact: ____ Relationship: __________________

Phone: (H)______________________________ (W)___________________________ (C)__________________________________

Financial Responsibility

Your Insurance claim will be filed, and all reasonable efforts will be made to collect reimbursement from your insurance company; however, this does not release the patient, the guarantor or responsible party from financial responsibility for services rendered. If the insurance company fails to honor claims filed for services rendered, it is ultimately your responsibility to pay for the services render by Progressive & Innovative Counseling Services. Co-pays are due at the time services are rendered.

Signature patient or guardian or responsible party ____Date ______

Release and Assignment

I understand it is necessary to release my demographic information in order to process my insurance claims.

Signature patient or guardian or responsible party ____Date ______

Consent for Treatment

I consent, agree, and authorize evolution and treatment by Progressive & Innovative Counseling Services, and I further confirm & acknowledge I reviewed the NOPP (Notice of Privacy Policy) outlining HIPAA, Hi-Tech act, and FCC compliance.

Signature patient or guardian or responsible party ____Date ______

Consent for Communication

I consent to consent receiving text reminders on my home/cell phone/email

Signature patient or guardian or responsible party ____Date _____

Missed Appointment

I understand that I will be billed $65.00 for any appointments that I do not cancel 24-hours prior to the scheduled appointment. Signature patient or guardian or responsible party ___________________________________Date ______

THE BURNS DEPRESSION CHECKLIST *

Instructions: The following is a list of symptoms that people sometimes have. Put a check (✓) in the space to the right that best describes how much that symptom or problem has bothered you during the past week.

		0 – Not at All	1 - Somewhat	2 - Moderately	3 – A Lot
1.	Sadness: Have you been feeling sad or down in the dumps?	☐	☐	☐	☐
2.	Discouragement: Does the future look hopeless?	☐	☐	☐	☐
3.	Low self-esteem: Do you feel worthless or think of yourself as a failure?	☐	☐	☐	☐
4.	Inferiority: Do you feel inadequate or inferior to others?	☐	☐	☐	☐
5.	Guilt: Do you get self-critical and blame yourself for everything?	☐	☐	☐	☐
6.	Indecisiveness: Do you have trouble making up your mind about things?	☐	☐	☐	☐
7.	Irritability and frustration: Have you been feeling resentful and angry a good deal of the time?	☐	☐	☐	☐
6.	Loss of interest in life: Have you lost interest in your career, your hobbies, your family, or your friends?	☐	☐	☐	☐
9.	Loss of motivation: Do you feel overwhelmed and have to push yourself hard to do things?	☐	☐	☐	☐
10.	Poor self-image: Do you think you're looking old or unattractive?	☐	☐	☐	☐
11.	Appetite changes: Have you lost your appetite? Or do you overeat or binge compulsively?	☐	☐	☐	☐
12.	Sleep changes: Do you suffer from insomnia and find it hard to get a good night's sleep? Or are you excessively tired and sleeping too much?	☐	☐	☐	☐
13.	Loss of libido: Have you lost your interest in sex?	☐	☐	☐	☐
14.	Hypochondriasis: Do you worry a great deal about your health?	☐	☐	☐	☐
15.	Suicidal impulses: Do you have thoughts that life is not worth living or think that you might be better off dead?	☐	☐	☐	☐

Add up your total score for the 15 symptoms and record it here: _____ Date: ____________

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Name:	D.O.B.: _/_/
F.S.P.#:	
Medicaid #:	IPRS / LME #:

THE BURNS ANXIETY INVENTORY *

Instructions: The following is a list of symptoms that people sometimes have. Put a check (✓) in the space to the right that best describes how much that symptom or problem has bothered you during the past week.

	Symptom List	0 – Not at All	1 - Somewhat	2 - Moderately	3 – A Lot
	CATEGORY I: ANXIOUS FEELINGS				
1.	Anxiety, nervousness, worry, or fear.	☐	☐	☐	☐
2.	Feeling that things around you are strange, unreal, or foggy.	☐	☐	☐	☐
3.	Feeling detached from all or part of your body.	☐	☐	☐	☐
4.	Sudden unexpected panic spells.	☐	☐	☐	☐
5.	Apprehension or a sense of impending doom.	☐	☐	☐	☐
6.	Feeling tense, stressed, “uptight”, or on edge,	☐	☐	☐	☐
	CATEGORY II: ANXIOUS THOUGHTS				
7.	Difficulty concentrating.	☐	☐	☐	☐
8.	Racing thoughts or having your mind jump from one thing to the next.	☐	☐	☐	☐
9.	Frightening fantasies or daydreams.	☐	☐	☐	☐
10.	Feeling that you’re on the verge of losing control.	☐	☐	☐	☐
11.	Fears of cracking up or going crazy.	☐	☐	☐	☐
12.	Fears of fainting or passing out.	☐	☐	☐	☐
13.	Fears of physical illnesses or heart attacks or dying.	☐	☐	☐	☐
14.	Concerns about looking foolish or inadequate in front of others.	☐	☐	☐	☐
15.	Fears of being alone, isolated, or abandoned.	☐	☐	☐	☐
16.	Fears of criticism or disapproval.	☐	☐	☐	☐
17.	Fears that something terrible is about to happen.	☐	☐	☐	☐
	CATEGORY III: PHYSICAL SYMPTOMS				
18.	Skipping or racing or pounding of the heart (sometimes called “palpitations”).	☐	☐	☐	☐
19.	Pain, pressure, or tightness in the chest.	☐	☐	☐	☐
20.	Tingling or numbness in the toes or fingers.	☐	☐	☐	☐
21.	Butterflies or discomfort in the stomach.	☐	☐	☐	☐
22.	Constipation or diarrhea.	☐	☐	☐	☐
23.	Restlessness or jumpiness.	☐	☐	☐	☐
24.	Tight, tense muscles	☐	☐	☐	☐
25.	Sweating not brought on by heat.	☐	☐	☐	☐
26.	A lump in the throat.	☐	☐	☐	☐

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	CATEGORY III: PHYSICAL SYMPTOMS *(Cont'd.)*	0 – Not at All	1 - Somewhat	2 - Moderately	3 – A Lot
27.	Trembling or shaking.	☐	☐	☐	☐
28.	Rubbery or "jelly" legs.	☐	☐	☐	☐
29.	Feeling dizzy, lightheaded, or off balance.	☐	☐	☐	☐
30.	Choking or smothering sensations or difficulty breathing.	☐	☐	☐	☐
31.	Headaches or pains in the neck or back.	☐	☐	☐	☐
32.	Hot flashes or cold chills.	☐	☐	☐	☐
33.	Feeling tired, weak, or easily exhausted.	☐	☐	☐	☐

Add up your total score for the 33 symptoms and record it here: _____ Date: ___________

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QUESTIONNAIRE ON EATING AND WEIGHT PATTERNS-5

(QEWP-5)©

Thank you for completing this questionnaire. Please circle or check the appropriate number or response, and write in information where asked. You may skip any question you do not understand or do not wish to answer.

1. How tall are you? ____ feet ___ inches

2. How much do you weigh now (if you are unsure, please provide your best guess)? ________ pounds

3. What has been your highest adult weight ever (for women, when not pregnant)? ________ pounds

4. During the past three months, did you ever eat, in a short period of time--for example, a two-hour period-- what most people would think was an unusually large amount of food? ___ Yes ___ No ___ N/A

5. During the times when you ate an unusually large amount of food, did you ever feel you could not stop eating or control what or how much you were eating? ____ Yes ___ No ___ NA

6. During the past three months, how often, on average, did you have episodes like this -- that is, eating large amounts of food plus the feeling that your eating was out of control? (There may have been some weeks when this did not happen -- just average those in):

   _____ N/A or
   _____ Less than 1 episode per week
   _____ 1 episode per week
   _____ 2-3 episodes per week
   _____ 4-7 episodes per week
   _____ 8-13 episodes per week
   _____ 14 or more episodes per week

7. Did you usually have any of the following experiences during these episodes? _____ Yes ______ No _____ N/A
   Select as many that apply if answered yes above:

   _____ Eating much more rapidly than normal?
   _____ Eating until feeling uncomfortably full?
   _____ Eating large amounts of food when not feeling physically hungry?
   _____ Eating alone because of feeling embarrassed by how much you were eating
   _____ Feeling disgusted with yourself, depressed, or feeling very guilty afterward

8. Think about a typical episode when you ate this way (that is, when you ate a large amount of food and felt your eating was out of control), what time of day did the episode start? ______ N/A; or

   ___ (8 AM to 12 Noon) ___ (12 Noon to 4 PM) ___ (4 PM to 8 PM) ___ (8 PM to 12 Midnight) ___ (12 Midnight to 8 AM)

9. As best you can remember, please list everything you ate and drank during that episode. Please list the foods eaten and liquids consumed during the episode. Be specific - include brand names where possible and amounts or portion sizes as best you can estimate.

   ____
   ____
   ____

10. In general, during the past three months, how upset were you by these episodes (when you ate a large amount of food and felt your eating was out of control)?

_____ Not at all _____ Slightly _____ Moderately _____ Greatly _____ Extremely

11. During the past three months, did you ever make yourself vomit to avoid gaining weight after episodes of eating like you described (when you ate a large amount of food and felt your eating was out of control)? _____ Yes _____ No

12. During the past three months, did you ever take more than the recommended dose of laxatives in order to avoid gaining weight after episodes of eating like you described (when you ate a large amount of food and felt your eating was out of control)? _____Yes _____ No

13. During the past three months, did you ever take more than the recommended dose of diuretics (water pills) to avoid gaining weight after episodes of eating like you described (when you ate a large amount of food and felt your eating was out of control)? _____ Yes _____ No

14. During the past three months, did you ever fast – for example, not eat anything at all for at least 24 hours -- to avoid gaining weight after episodes of eating like you described (when you ate a large amount of food and felt your eating was out of control)? _____ Yes _____ No

15. During the past three months, did you ever exercise excessively –for example, exercised even though it interfered with important activities or despite being injured –specifically to avoid gaining weight after episodes of eating like you described (when you ate a large amount of food and felt your eating was out of control)? _____ Yes _____ No

16. During the past three months, did you ever take more than the recommended dose of a diet pill to avoid gaining weight after episodes of eating like you described (when you ate a large amount of food and felt your eating was out of control)? _____Yes _____ No

17. During the past three months, on average, how important has your weight or shape been in how you feel about or evaluate yourself as a person?

_____ Weight and shape were not very important
_____ Weight and shape played a part in how you felt about yourself
_____ Weight and shape were among the main things that affected how you felt about yourself
_____ Weight and shape were the most important things that affected how you felt about yourself

18. Answer the following questions based on your cultural, religious, or spiritual beliefs:

If my (health; condition) worsens, it is up to God to determine whether I will feel better again.	__ True	__ False	___ N/A
Most things that affect my (health; condition) happen because of God.	__ True	__ False	___ N/A
God is directly responsible for my (health; condition) getting better or worse.	__ True	__ False	___ N/A
Whatever happens to my (health; condition) is God's will.	__ True	__ False	___ N/A
Whether or not my (health; condition) improves is up to God.	__ True	__ False	___ N/A
God is in control of my (health; condition).	__ True	__ False	___ N/A

19. Last name____________________________ First name______________________ M.I.____ Date__________

20. Age ______ years Sex: Male____ Female___ What is your ethnic/racial background? ______________