Jim B. Keller, Ph.D.
Specialists in Psychological Counseling & Consulting, PLLC

Pre-Surgical Psychological Consultation Assessment Packet

PURPOSE: The following questionnaires are simply used to gather information about your personal history, health habits, eating patterns, and emotional concerns and well-being.

The information you provide here allows your visit with the psychologist to be completed in far less time (often a single 60-minute interview). Your completed documents will remain confidential.

PLEASE BRING THE COMPLETED PACKET TO YOUR PSYCHOLOGICAL CONSULTATION APPOINTMENT

List of Forms & Questionnaires:

- ❑ Consent to Receive Evaluation or Treatment (1 page)
- ❑ Personal History Questionnaire (8 pages)
- ❑ Stress Symptom Checklist (1 page)
- ❑ BPS-SF (1 page)
- ❑ W-MQL (1 page)
- ❑ EAT-SF (1 page)
- ❑ EAT-26 (1 page)
- ❑ DASS 21 (1 page)
- ❑ Burns Anxiety Inventory (1 page)
- ❑ Burns Depression Checklist (1 page)
- ❑ AUDIT-Alcohol Screening (1 page)

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CONSENT TO RECEIVE EVALUATION OR TREATMENT

I, _____(patient or guardian name), consent to receive (or have my dependent receive) evaluation, treatment, and/or support services from *Dr. Jim Keller and Staff.* I have been provided an explanation of my rights as a patient and/or guardian and understand that consent to services does not waive my rights as recognized under law.

I understand that fees for services are my responsibility (or responsibility of legal guardian) and that I am required to render payment for services as those services are provided.

I understand that my doctors will be basing clinical judgments and recommendations upon the information I choose to provide and that the purposeful omission of relevant historical or other information could impede the effective disposition of my care. I hereby attest that I will, to the best of my ability, provide all relevant information and will not purposefully distort or withhold information or evade questions asked of me either written or oral.

I understand that my communications with *Dr. Keller & staff* and my treatment records are confidential and may not be released except under the following conditions or circumstances or where otherwise provided by law:

- My written consent has been provided to allow communication (written, verbal, and release of records) between *Dr. Keller & staff* and other parties relevant to my care.
- The need arises for *Dr. Keller & staff* to disclose my treatment information in order to protect the rights and safety of myself or others in such cases that:
  a. I present a clear and present danger to myself and refuse explicitly or by behavior to voluntarily accept appropriate treatment OR
  b. I communicate an explicit threat to kill or inflict serious bodily injury upon an identified person with the intent and ability to carry out the threat OR
  c. *Dr. Keller's staff* become aware of a child or adult whose welfare may be at risk such that it rises to the level of suspicion as outlined in Oklahoma law for mandatory reporting of child abuse and neglect or the abuse or neglect of an adult (e.g., the elderly or incapacitated).
- For supervised review by federal, state, and/or local contract funding sources or accrediting bodies to verify and evaluate the provision of services due to third party funding and/or certification requirements.
- Upon the delivery of a court order with proper jurisdiction.

I understand that some of my treatment information (e.g., identifying information, diagnosis, treatment planning) will be disclosed by *Dr. Keller or staff* to my insurance company or other relevant third party payers to ensure proper payment for services.

IN THE EVENT OF AN EMERGENCY STAFF MAY CONTACT:

_____ AT (_____) _____ - _____

_____ _____

Patient signature Date

_____ _____

Guardian or Legally Approved Representative Date

_____ _____

Staff Witness Date

Revised 7/28/09

Jim R. Keller, Ph.D.
Specialists in Psychological Counseling & Consulting, PLLC

The BPS Method™

Personal History Questionnaire ©

(SURGICAL PATIENT VERSION)

CONFIDENTIAL

Patient Name: _____

Date Completed: _____

☐ IDENTIFYING INFORMATION

Client's Last Name: _____ First Name: _____ MI: ____

Last 4 Digits of SSN: _____ DOB: _____ Gender: M F Age:_____

Marital Status: Married Single Divorced Other_____

City of Residence: _____ State: _____

☐ EDUCATIONAL HISTORY

What is your educational background? Circle ALL that apply:

GED High School Diploma Technical School Associate's Degree Bachelor's Degree Graduate Degree

Other:_____ **Currently attending school?** (name of school):_____

Military Service? No ☐ Yes ☐ Branch? _____ **Years of Service?** _____

☐ EMPLOYMENT HISTORY

Employed? No ☐ Yes ☐ **Employer?**_____ **Job Title?** _____

Are you currently receiving medical disability? No ☐ Yes ☐ **If yes, explain:** _____

_____

☐ FAMILY HISTORY

If married, how long have you been married? _____ **How many times have you been married?** _____

Is your relationship generally STABLE? ☐Yes ☐No **Is your partner supportive of surgery?** ☐Yes ☐No

If divorced, what year was your most recent divorce? _____

How many biological or adopted children do you have? _____ **Ages?** _____

Please list ALL individuals CURRENTLY IN YOUR HOME:

Name	Age	Relationship to Patient (e.g., spouse, son, daughter etc.)

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GENOGRAM

PATIENT'S SUPPORT SYSTEM

From whom do you get EMOTIONAL support? Circle ALL that apply:

Spouse Partner Friends Family Church Other _____

Have you attended a SUPPORT GROUP yet? No ❑ Yes ❑ Month/Year Attended:_____

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- ❑ **Support System is:** Excellent Good Adequate Lacking Other
- ❑ **Partner/Support System Supportive of WLS?:** YES NO NA
- ❑ **Has pt interacted w/ or witnessed WLS pts personally?** YES NO NA

COMMENTS:

LEGAL HISTORY

Have you been involved in ANY form of legal action within the past year? No ❑ Yes ❑

If yes, please explain:_____

_____

LANGUAGE/VISUAL FUNCTIONING

Do you have any problems with speech, hearing, or visual functioning? No ❑ Yes ❑ Unknown ❑

If yes, please explain: _____

_____

INTELLECTUAL FUNCTIONING

Do you CURRENTLY have problems with learning or reading? No ❑ Yes ❑ Unknown ❑

If yes, please explain: _____

_____

Have you EVER been diagnosed with intellectual or learning disabilities? No ❑ Yes ❑ Unknown ❑

If yes, please explain: _____

_____

Have you EVER suffered a significant head injury? No ❑ Yes ❑ Unknown ❑

If yes, please explain (include year injury incurred): _____

_____

Do you have any significant problems with short or long-term memory? No ❑ Yes ❑ Unknown ❑

If yes, please explain: _____

Client's Last Name_____ First_____ MI____

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☐ Mental Status WNL ☐ Mental Status Concerns

COMMENTS: _____

☐ RELEVANT MEDICAL HISTORY (details of medical history will be gleaned from medical chart)

Please List CURRENT Medical Conditions (e.g., *"Diabetes-1995; Arthritis-1985 to Present"* etc.)

1) _____

2) _____

3) _____

4) _____

5) _____

☐ MENTAL HEALTH HISTORY

Have you EVER had ANY TYPE of Counseling/Psychotherapy No ☐ Yes ☐ If yes, please list below:

Year of Services	Provider (Name of Agency, Hospital and/or Clinician)	Reason for Services

Have you EVER been hospitalized in a PSYCHIATRIC facility? No ☐ Yes ☐ If yes, please list below:

Year of Admission	Name of Hospital/Facility	Length of Stay	Reason for Treatment

☐ SYMPTOMS/PSYCHOLOGICAL CONCERNS

Please circle ALL of the following with which you have suffered and denote "PAST" and/or "NOW":

Depression	Past ☐	Now ☐	Suicidal Thoughts	Past ☐	Now ☐
Generalized Anxiety	Past ☐	Now ☐	Suicidal Behavior	Past ☐	Now ☐
Panic Attacks	Past ☐	Now ☐	Schizophrenia	Past ☐	Now ☐
Obsessive-Compulsive	Past ☐	Now ☐	Relationship Problems	Past ☐	Now ☐
Personality Disorder	Past ☐	Now ☐	Bulimia/Anorexia	Past ☐	Now ☐
Low Self-Esteem	Past ☐	Now ☐	Negative Body Image	Past ☐	Now ☐
High Stress	Past ☐	Now ☐	Fears / Phobias	Past ☐	Now ☐
Loneliness	Past ☐	Now ☐	Health Concerns	Past ☐	Now ☐

Client's Last Name_____ First_____ MI____

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☐ No Psych. Treatment History ☐ Patient Has Received Mental Health Tx

☐ No Childhood Abuse History ☐ Childhood Abuse Reported

SYMPTOMS & RELEVANT HISTORY:

Client's Last Name_____ First_____ MI____

Please list MEDICATIONS you CURRENTLY take for PSYCHOLOGICAL concerns (e.g., antidepressants):

Prescribing Physician	Name of Medication	Dosage of Medication	Length of Time on Medication	Reason for taking the Medication

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☐ NO History of Psychotropic Medications ☐ History of Psychotropic Medications

CURRENT MEDS: _____

COMMENTS: _____

_____

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☐ Psychological Testing WNL? Comments: _____

DIAGNOSIS: AXIS I: ☐ _____ ☐ _____

AXIS II: ☐ _____ ☐ _____

COMMENTS: _____

_____

☐ SUBSTANCE USE HISTORY

NICOTINE USE

Do you smoke cigarettes currently? No ☐ Yes ☐

If you smoke, how many packs per day? Less than 1/2 Pack ☐ Less than 1 Pack ☐

Between 1-2 Packs ☐ More than 2 Packs ☐

If you use tobacco, what type? _____

ALCOHOL USE

Have you ever consistently ABUSED alcohol? No ☐ Yes ☐

If yes, what time frame (what year to what year) did you abuse alcohol? _____

Do you CURRENTLY drink alcohol? No ☐ Lightly ☐ Heavily ☐ **Drinks per Week?** _____

Client's Last Name _____ First _____ MI ____

Have you ever had any formal DRUG/ALCOHOLTREATMENT? No ❑ Yes ❑ If yes, please list:

Year of Treatment	Name of Hospital/Facility	Length of Stay	Reason for Treatment

DRUG USE

Have you ever ABUSED any legal or illegal drug/substance? No ❑ Yes ❑

Please check ALL substances/drugs that you have used inappropriately and the age range the use occurred:

❑ Heroin Ages___ ❑ Morphine Ages___ ❑ Methadone Ages___

❑ Cocaine Ages___ ❑ Amphetamine/Crank Ages___ ❑ LSD Ages___

❑ Ecstasy Ages___ ❑ MDD, MTP, STP Ages___ ❑ Mushrooms Ages___

❑ Marijuana Ages___ ❑ Hashish Ages___ ❑ Steroids Ages___

❑ Inhalants Ages_____ ❑ Other_____ Ages___

Do you CURRENTLY use any ILLEGAL SUBSTANCES? No ❑ Yes ❑

If yes, please explain:_____

Do you CURRENTLY use any PRESCRIPTION PAIN KILLERS? No ❑ Yes ❑

If yes, please explain:_____

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☐ **No History of Substance Abuse** ☐ **Substance Abuse Hx Reported**

COMMENTS:_____

_____

_____

_____

☐ WEIGHT LOSS HISTORY

YOUR CURRENT WEIGHT: _____ lbs. Height: _____ ft. _____ in. BMI: _____

Have you PREVIOUSLY UNDERGONE WEIGHT LOSS SURGERY? No ❑ Yes ❑

Year of Surgery: _____ Type of Surgery:_____ Surgeon: _____

Pre-Surgical Weight: _____ lbs. Lowest Weight Reached AFTER Surgery: _____ lbs.

Client's Last Name_____ First_____ MI___

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COMMENTS:

Have you ever taken PRESCRIPTION medications to lose weight? No ☐ Yes ☐ If yes, please list:

Year/s Prescribed	Name of Medication	Length of Time	Prescribing Physician

GOAL WEIGHT

What weight (range) do you hope to eventually reach ? _____ lbs. (Lowest) TO _____ lbs. (Highest Acceptable)

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EATING HISTORY

Have you ever engaged in BULIMIA (e.g., throwing up after meals to lose weight)? No ☐ Yes ☐

If yes, please explain: _____

Have you ever engaged in ANOREXIA (e.g., starving yourself for extended periods)? No ☐ Yes ☐

If yes, please explain: _____

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☐ **No Bulimic or Anorexic Behavior** ☐ **Eating D/O History Reported**

COMMENTS:

Circle the description/s that best describe your eating habits (CIRCLE ALL THAT APPLY):

Overeat At Meals	Past ☐	Now ☐	Evening/Night Eating	Past ☐	Now ☐
Snack/Graze	Past ☐	Now ☐	Skip Meals	Past ☐	Now ☐
Sweet Eater	Past ☐	Now ☐	Soda Pop Habit	Past ☐	Now ☐
Eat Until Sick	Past ☐	Now ☐	Emotional Eating	Past ☐	Now ☐

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☐ **Problematic Eating Patterns Reported**
☐ **See Comments**

COMMENTS:

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KNOWLEDGE OF PROCEDURE

☐ **Patient Aware of Risks** ☐ **Patient Aware of Dietary Protocol** ☐ **Patient Aware of Side Effects**

COMMENTS:

DOES PROCEDURE SEEM TO FIT PATIENT'S EATING STYLE? YES NO

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SURGICAL VIABLITY & DISPOSITION

☐ **CLEARED UNCONDITIONALLY** ☐ **CASE PENDING FURTHER ACTION**
☐ **CLEARED W/ RECOMMENDATIONS** ☐ **SURGERY NOT RECOMMENDED**

DETAILS:

Client's Last Name_____ First_____ MI____

Stress Symptom Checklist

Source: *The Anxiety and Phobia Workbook* by Edmund J. Bourne, Ph.D.

Instructions: Check each item that describes a symptom you have experienced to any significant degree during the last month. Then, total the number of items checked.

Physical Symptoms

- ☐ Headaches [migraine or tension]
- ☐ Backaches
- ☐ Tight muscles
- ☐ Neck and shoulder pain
- ☐ Jaw tension
- ☐ Muscle cramps, spasms
- ☐ Nervous stomach
- ☐ Other pain
- ☐ Nausea
- ☐ Insomnia [sleeping poorly]
- ☐ Fatigue, lack of energy
- ☐ Cold hands and/or feet
- ☐ Tightness or pressure in the head
- ☐ High blood pressure
- ☐ Diarrhea
- ☐ Skin condition [e.g., rash]
- ☐ Allergies
- ☐ Teeth grinding
- ☐ Digestive upsets [cramps, bloating]
- ☐ Heart beats rapidly or pounds, even at rest
- ☐ Stomach pain or ulcer
- ☐ Constipation
- ☐ Hypoglycemia
- ☐ Appetite change
- ☐ Colds
- ☐ Profuse perspiration
- ☐ Overeating
- ☐ Weight change
- ☐ When nervous, use of alcohol, cigarettes, or recreational drugs

Psychological Symptoms

- ☐ Anxiety
- ☐ Depression
- ☐ Confusion or "spaciness"
- ☐ Irrational fears
- ☐ Compulsive behavior
- ☐ Forgetfulness
- ☐ Feeling "overloaded" or overwhelmed
- ☐ Hyperactivity; feeling you can't slow down
- ☐ Mood swings
- ☐ Loneliness
- ☐ Problems with relationships
- ☐ Dissatisfied/unhappy with work
- ☐ Difficult concentrating
- ☐ Frequent irritability
- ☐ Restlessness
- ☐ Frequent boredom
- ☐ Frequent worrying or obsessing
- ☐ Frequent guilt
- ☐ Temper flare-ups
- ☐ Crying spells
- ☐ Nightmares
- ☐ Apathy
- ☐ Sexual problems

Total Number of Items Checked: _____

Evaluate your stress level as follows:

Number of Items Checked	Stress Level
0-7	*Low*
8-14	*Moderate*
15-21	*High*
22+	*Very High*

The BPS Method™

BPS-SF©

Bariatric Psychosocial Screening - Short Form

Developed by Jim R. Keller, Ph.D.

Patient Name:_____ Date:_____

DIRECTIONS: Please rate from 1-5 how often in the PAST FEW MONTHS you have experienced the issue listed.

	NEVER 1	2	SOMETIMES 3	4	OFTEN 5
DOMAIN I					
1. I feel sad and depressed.	①	②	③	④	⑤
2. I have thoughts of hurting myself.	①	②	③	④	⑤
3. I find it hard to care about things like I used to.	①	②	③	④	⑤
4. I don't enjoy the things I'm still able to do.	①	②	③	④	⑤
5. I feel like my future isn't going to work out.	①	②	③	④	⑤
DOMAIN II	1	2	3	4	5
1. I feel anxious and restless.	①	②	③	④	⑤
2. I experience episodes of panic .	①	②	③	④	⑤
3. I have fears that others don't seem to have.	①	②	③	④	⑤
4. My worries overwhelm me.	①	②	③	④	⑤
5. I have difficulty shutting off my mind.	①	②	③	④	⑤
DOMAIN III	1	2	3	4	5
1. I avoid eating for 1 or more days to lose weight.	①	②	③	④	⑤
2. I vomit after I eat in order to lose weight.	①	②	③	④	⑤
3. I use laxatives or water pills to lose weight.	①	②	③	④	⑤
4. I diet despite others telling me I'm far too thin.	①	②	③	④	⑤
5. I exercise obsessively to lose weight.	①	②	③	④	⑤
DOMAIN IV	1	2	3	4	5
1. I hear or see things that are not actually there.	①	②	③	④	⑤
2. I have bizarre experiences that most don't have.	①	②	③	④	⑤
3. I feel like my mind isn't working right.	①	②	③	④	⑤
4. My emotions don't seem to fit the situation.	①	②	③	④	⑤
5. I cannot control my thoughts.	①	②	③	④	⑤
DOMAIN V	1	2	3	4	5
1. I feel isolated and alone.	①	②	③	④	⑤
2. I feel like others don't understand me.	①	②	③	④	⑤
3. I avoid being with people.	①	②	③	④	⑤
4. I feel no one will be there for me in rough times.	①	②	③	④	⑤
5. I feel like others are out to get me.	①	②	③	④	⑤

* The BPS-SF© is a clinical screening instrument and psychometric validation has not yet been completed.

Weight Mediated Quality of Life- Short Form (WMQL-*SF*)

Developed by Jim R. Keller, Ph.D.

Patient Name:_____ Date:_____

Please read each question and rate from 1-5 how much you **AGREE** (lower score) or **DISAGREE** (higher score) with the statement.

Self-Esteem

	AGREE 1	2	AVERAGE 3	4	DISAGREE 5
1. I like myself as a person.	1	2	3	4	5
2. I like the way I look.	1	2	3	4	5
3. I like how other people think I look.	1	2	3	4	5
4. I am a good and decent person.	1	2	3	4	5
5. I am a confident person.	1	2	3	4	5

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Self-Esteem Composite Score → ☐
(Average of item scores)

Mobility

	AGREE 1	2	AVERAGE 3	4	DISAGREE 5
1. I can walk and get around.	1	2	3	4	5
2. I can do physically strenuous tasks.	1	2	3	4	5
3. I can do daily tasks (e.g., tie shoes)	1	2	3	4	5
4. I can climb stairs.	1	2	3	4	5
5. I can exercise as I should.	1	2	3	4	5

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Mobility Composite Score → ☐
(Average of item scores)

Health

	AGREE 1	2	AVERAGE 3	4	DISAGREE 5
1. I feel healthy and energetic.	1	2	3	4	5
2. I'm generally healthy for my age.	1	2	3	4	5
3. I can move without pain.	1	2	3	4	5
4. I take few (or no) medications.	1	2	3	4	5
5. My health is getting better.	1	2	3	4	5

For Office Use Only

Health Composite Score → ☐
(Average of item scores)

WMQL-*SF* Composite Score Interpretation

1.0-2.5	**Above Average Quality of Life**
2.6-3.5	**Average Quality of Life**
3.6-4.5	**Below Average Quality of Life**
4.6-5.0	**Poor Quality of Life**

Revised 1/18/16

Eating Attitudes & Triggers – Short Form (EAT-*SF*)

Developed by Jim R. Keller, Ph.D.

Patient Name:_____ Date:_____

Please read each question and rate from 1-5 how often you engage in the behavior to the left. Please note that the HIGHER THE NUMBER, the MORE you engage in the behavior.

Biological

	RARELY 1	2	SOMETIMES 3	4	OFTEN 5
1. I skip meals.	1	2	3	4	5
2. I avoid eating meats and protein.	1	2	3	4	5
3. I eat starches and sweets.	1	2	3	4	5
4. I am tired and do not sleep well.	1	2	3	4	5
5. I drink less fluid than I should.	1	2	3	4	5

Biological Composite Score (Average of item scores) → For Office Use Only ☐

Psychological

	RARELY 1	2	SOMETIMES 3	4	OFTEN 5
1. I eat when I am bored.	1	2	3	4	5
2. I eat when I am stressed out.	1	2	3	4	5
3. I eat to celebrate.	1	2	3	4	5
4. I eat when happy or as reward.	1	2	3	4	5
5. I eat when I'm restless.	1	2	3	4	5

Psychological Composite Score (Average of item scores) → For Office Use Only ☐

Environmental

	RARELY 1	2	SOMETIMES 3	4	OFTEN 5
1. I eat badly at social events.	1	2	3	4	5
2. I eat badly at restaurants.	1	2	3	4	5
3. I eat badly in certain situations.	1	2	3	4	5
4. I eat food because it is handy.	1	2	3	4	5
5. The time of day impacts my eating.	1	2	3	4	5

Environmental Composite Score (Average of item scores) → For Office Use Only ☐

***BPS* EAT-SF Composite Score Interpretation**

1.0-2.5	**Below Average Influence Over Your Eating**
2.6-3.5	**Average Influence Over Your Eating**
3.6-4.5	**Above Average Influence Over Your Eating**
4.6-5.0	**Notable Influence Over Your Eating**

Revised 2/26/19

Patient Name_____ Date:_____

Eating Attitudes Test© (EAT-26)

Instructions: This is a screening measure to help you determine whether you might have an eating disorder that needs professional attention. This screening measure is not designed to make a diagnosis of an eating disorder or take the place of a professional consultation. Please fill out the below form as accurately, honestly and completely as possible. There are no right or wrong answers. All of your responses are confidential.

Part A: Complete the following questions:

1) Birth Date Month: .....Day: .....Year: ..... 2) Gender: ❑ Male ❑ Female

3) Height Feet: .....Inches: .....

4) Current Weight (lbs.):.....5) Highest Weight (excluding pregnancy):.....

6) Lowest Adult Weight: .....7) Ideal Weight:.....

Part B: Please check a response for each of the following statements:	Always	Usually	Often	Sometimes	Rarely	Never
1. Am terrified about being overweight.	❑	❑	❑	❑	❑	❑
2. Avoid eating when I am hungry.	❑	❑	❑	❑	❑	❑
3. Find myself preoccupied with food.	❑	❑	❑	❑	❑	❑
4. Have gone on eating binges where I feel that I may not be able to stop.	❑	❑	❑	❑	❑	❑
5. Cut my food into small pieces.	❑	❑	❑	❑	❑	❑
6. Aware of the calorie content of foods that I eat.	❑	❑	❑	❑	❑	❑
7. Particularly avoid food with a high carbohydrate content (i.e. bread, rice, potatoes, etc.)	❑	❑	❑	❑	❑	❑
8. Feel that others would prefer if I ate more.	❑	❑	❑	❑	❑	❑
9. Vomit after I have eaten.	❑	❑	❑	❑	❑	❑
10. Feel extremely guilty after eating.	❑	❑	❑	❑	❑	❑
11. Am preoccupied with a desire to be thinner.	❑	❑	❑	❑	❑	❑
12. Think about burning up calories when I exercise.	❑	❑	❑	❑	❑	❑
13. Other people think that I am too thin.	❑	❑	❑	❑	❑	❑
14. Am preoccupied with the thought of having fat on my body.	❑	❑	❑	❑	❑	❑
15. Take longer than others to eat my meals.	❑	❑	❑	❑	❑	❑
16. Avoid foods with sugar in them.	❑	❑	❑	❑	❑	❑
17. Eat diet foods.	❑	❑	❑	❑	❑	❑
18. Feel that food controls my life.	❑	❑	❑	❑	❑	❑
19. Display self-control around food.	❑	❑	❑	❑	❑	❑
20. Feel that others pressure me to eat.	❑	❑	❑	❑	❑	❑
21. Give too much time and thought to food.	❑	❑	❑	❑	❑	❑
22. Feel uncomfortable after eating sweets.	❑	❑	❑	❑	❑	❑
23. Engage in dieting behavior.	❑	❑	❑	❑	❑	❑
24. Like my stomach to be empty.	❑	❑	❑	❑	❑	❑
25. Have the impulse to vomit after meals.	❑	❑	❑	❑	❑	❑
26. Enjoy trying new rich foods.	❑	❑	❑	❑	❑	❑

Part C: Behavioral Questions. In the past 6 months have you:	Never	Once a month or less	2-3 times a month	Once a week	2-6 times a week	Once a day or more
A. Gone on eating binges where you feel that you may not be able to stop?	❑	❑	❑	❑	❑	❑
B. Ever made yourself sick (vomited) to control your weight or shape?	❑	❑	❑	❑	❑	❑
C. Ever used laxatives, diet pills or diuretics (water pills) to control your weight or shape?	❑	❑	❑	❑	❑	❑
D. Exercised more than 60 minutes a day to lose or to control your weight?	❑	❑	❑	❑	❑	❑
E. Lost 20 pounds or more in the past 6 months	❑ Yes			❑ No		

• Defined as eating much more than most people would under the same circumstances and feeling that eating is out of control.

EAT-26: Garner et al. 1982, Psychological Medicine, 12, (871 878); adapted/reproduced by D. Garner with permission.

DASS21

Name: Date:

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you **over the past week**. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all this past week
1 Applied to me to some degree, or some of the time this past week
2 Applied to me to a considerable degree or a good part of time this past week
3 Applied to me very much or most of the time this past week

		NEVER			OFTEN
1 (s)	I found it hard to wind down	0	1	2	3
2 (a)	I was aware of dryness of my mouth	0	1	2	3
3 (d)	I couldn't seem to experience any positive feeling at all	0	1	2	3
4 (a)	I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5 (d)	I found it difficult to work up the initiative to do things	0	1	2	3
6 (s)	I tended to over-react to situations	0	1	2	3
7 (a)	I experienced trembling (e.g. in the hands)	0	1	2	3
8 (s)	I felt that I was using a lot of nervous energy	0	1	2	3
9 (a)	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10 (d)	I felt that I had nothing to look forward to	0	1	2	3
11 (s)	I found myself getting agitated	0	1	2	3
12 (s)	I found it difficult to relax	0	1	2	3
13 (d)	I felt down-hearted and blue	0	1	2	3
14 (s)	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15 (a)	I felt I was close to panic	0	1	2	3
16 (d)	I was unable to become enthusiastic about anything	0	1	2	3
17 (d)	I felt I wasn't worth much as a person	0	1	2	3
18 (s)	I felt that I was rather touchy	0	1	2	3
19 (a)	I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	0	1	2	3
20 (a)	I felt scared without any good reason	0	1	2	3
21 (d)	I felt that life was meaningless	0	1	2	3

*Adapted and revised by Jim R. Keller, PhD 2019

Burns Anxiety Inventory*

Name: _____ Date of Test: _____

DOB: _____

INSTRUCTIONS: **Mark the appropriate box with an X to answer each question.** **Please be honest and be sure to answer all questions on the page.** **Indicate how much each of the following symptoms has been bothering you in the past several days.**		0- Not at all	1- Somewhat	2- Moderately	3- A lot
CATEGORY I: ANXIOUS FEELINGS					
1	Anxiety, nervousness, worry or fear				
2	Feeling things around you are strange 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, stress, "uptight" or on edge				
CATEGORY II: ANXIOUS THOUGHTS					
7	Difficulty concentrating				
8	Racing thoughts				
9	Frightening fantasies or daydreams				
10	Feeling on the verge of losing control				
11	Fears of cracking up or going crazy				
12	Fears of fainting or passing out				
13	Fears of illnesses, heart attacks, or dying				
14	Fears of looking foolish in front of others				
15	Fears of being alone, isolated or abandoned				
16	Fears of criticism or disapproval				
17	Fears that something terrible will happen				
CATEGORY II: PHYSICAL SYMPTOMS					
18	Skipping, racing or pounding of the heart				
19	Pain, pressure or tightness of 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				
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				

Office Use Only:
Score: _____
Test #: _____

Burn's Depression Checklist

Name: Date:

Instructions: Put a check ☑ to indicate how much you have experienced each symptom during the past week, including today. Please answer all 25 items.		0 = Not At All	1 = Somewhat	2 = Moderately	3 = A Lot	4 = Extremely
Thoughts and Feelings						
1	Feeling sad or down in the dumps					
2	Feeling unhappy or blue					
3	Crying spells or tearfulness					
4	Feeling discouraged					
5	Feeling hopeless					
6	Low self-esteem					
7	Feeling worthless or inadequate					
8	Guilt or shame					
9	Criticizing yourself or blaming others					
10	Difficulty making decisions					
Activities and Personal Relationships						
11	Loss of interest in family, friends or colleagues					
12	Loneliness					
13	Spending less time with family or friends					
14	Loss of motivation					
15	Loss of interest in work or other activities					
16	Avoiding work or other activities					
17	Loss of pleasure or satisfaction in life					
Physical Symptoms						
18	Feeling tired					
19	Difficulty sleeping or sleeping too much					
20	Decreased or increased appetite					
21	Loss of interest in sex					
22	Worrying about your health					
Suicidal Urges						
23	Do you have any suicidal thoughts?					
24	Would you like to end your life?					
25	Do you have a plan for harming yourself?					
	Please Total Your Score on Items 1-25 Here:					

Total Score	Level of Depression
No Depression	0-5
Normal but unhappy	6-10
Mild depression	11-25
Moderate depression	26-50
Severe depression	51-75
Extreme depression	76-100

From, *Feeling Good: The New Mood Therapy, David D. Burns, M.D.*

Alcohol screening questionnaire (AUDIT)

Our clinic asks all patients about alcohol use at least once a year. Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

One drink equals:

12 oz. beer

5 oz. wine

1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the past

	I	II	III	IV
M:	0-4	5-14	15-19	20+
W:	0-3	4-12	13-19	20+