NEW PATIENT QUESTIONNAIRE

Springfield clinic

A COMMUNITY OF CARING

What to Expect

By learning as much as we can about your current and previous nutrition, activity and support status, we can tailor our education and treatment plan to best meet your needs. We realize this is a lengthy questionnaire and some of the questions may seem repetitive; however, this information is reviewed by our bariatric care team and used to justify coverage by your insurance. Please be as thorough, accurate and detailed as possible.

1. Take your time
2. Answer honestly
3. Use a pen or pencil
4. Complete all three sections before your appointment.
5. Initial every page

Please Begin Here

Demographic Information

First name: _____ Middle name: _____ Last name: _____

Date of birth: ☐☐ ☐☐ ☐☐☐☐ Today's date: ☐☐☐☐☐☐

Name you go by: _____ Email: _____

Address: _____ City: _____

State: _____ Zip code: _____ Phone number: _____

Please circle Y (yes) or N (no) to grant us the following permissions for communication of:

	Email	Text	Leave a Voicemail
Appointment reminders	Y N	Y N	Y N
Support group reminders	Y N	Y N	Y N
Program updates, news	Y N	Y N	Y N
Invitations to online events	Y N	Y N	Y N
Invitations to follow us on social media	Y N	Y N	Y N

Initial: _____

Previous Weight Loss Attempts

Please circle Y (yes) or N (no) for each type of attempt you've made. Provide dates if possible:

Self-Directed & Commercial Programs

Atkins™	Y	N	_____
Keto(genic)	Y	N	_____
Ornish	Y	N	_____
South Beach	Y	N	_____
Zone®	Y	N	_____
Noom	Y	N	_____
Nutrisystem®	Y	N	_____
WW™	Y	N	_____
DASH	Y	N	_____
Diabetic	Y	N	_____
Mayo Clinic	Y	N	_____
Mediterranean	Y	N	_____

Physician-Supervised Diet & Medications

Diet	Y	N	_____
Alli®	Y	N	_____
Contrave®	Y	N	_____
Phentermine	Y	N	_____
Qsymia®	Y	N	_____
Saxenda®	Y	N	_____
Wegovy™	Y	N	_____
Xenical	Y	N	_____
Other	Y	N	_____
Other	Y	N	_____
Other	Y	N	_____
Other	Y	N	_____

Weight History

Please be as accurate as possible.
If you're not sure, record your best estimate:

Current Weight	_____
Weight 1 Year Ago	_____
Weight 2 Years Ago	_____
Weight 10 Years Ago	_____
Highest Adult Weight	_____
Lowest Adult Weight	_____
Weight 5 Years Ago	_____

Surgical History

Please be as accurate as possible regarding any previous abdominal surgery:

Weight Loss Surgery	Y	N	_____
Hernia Repair	Y	N	_____
Gallbladder Removed	Y	N	_____
Other	Y	N	_____

Initial: _____

Education Preferences

Which do you prefer? Please circle all that apply.

Group/class setting*	Y	N
Individual appointments**	Y	N
Live instruction	Y	N
On-demand videos	Y	N
On-site at the clinic	Y	N
Remote via Microsoft Teams or Zoom	Y	N

**Group or classroom education is offered weekly and provides the opportunity to meet and connect with other patients. This can prompt discussions and questions you had not previously considered.*

***Individual appointments provide a more targeted approach. They may take longer to schedule.*

Technology Evaluation

We offer multiple options for your bariatric toolbox, including online/virtual support groups and apps. These options are only beneficial if you know how to use them and are comfortable doing so. Please tell us:

How often do you check email?	Daily	Weekly	Monthly	What's email?
How comfortable are you using apps on your phone?	Very ◯	Moderately ◯	Not very ◯	What are apps? ◯
Are you active on social media? *(Facebook, Instagram, Pinterest, etc.)*	Very ◯	Moderately ◯	Not very ◯	Not at all ◯
Do you have reliable internet access at home?	Yes ◯	No ◯		

On a scale of 1-5, where 1 is the lowest and 5 the highest, how likely are you to take advantage of the following?

App with written education materials	1	2	3	4	5
App with videos on demand	1	2	3	4	5
Remote/virtual support groups	1	2	3	4	5
Hints, tips, reminders via social media	1	2	3	4	5

Initial: _____

Motivation and Readiness to Change

Obesity is a multi-factorial, chronic disease. While there are multiple treatment options available, your response to individual or combined treatment options will vary. What we know for sure is setting realistic, achievable goals when someone is both motivated and ready to make lifelong changes results in better long-term outcomes.

Tell us what has motivated you to come in for treatment?

- ☐ A new obesity-related diagnosis (diabetes, high blood pressure, etc.).
- ☐ I feel tired all the time
- ☐ I want to be comfortable playing with my children/grandchildren.
- ☐ I want to improve my chances of pregnancy
- ☐ A conversation with my doctor
- ☐ Weight loss of a friend/family member

Tell us how ready you are to implement the following changes:

Committing to taking vitamin supplements daily	Very ◯	Moderately ◯	Not very ◯	Not at all ◯
Having my labs drawn at regular intervals	Very ◯	Moderately ◯	Not very ◯	Not at all ◯
Completing the three to six months of classes and appointments to meet insurance requirements	Very ◯	Moderately ◯	Not very ◯	Not at all ◯
Attending support groups on a monthly basis	Very ◯	Moderately ◯	Not very ◯	Not at all ◯
Eliminating carbonated beverages	Very ◯	Moderately ◯	Not very ◯	Not at all ◯
Incorporating stress reduction techniques	Very ◯	Moderately ◯	Not very ◯	Not at all ◯
Focusing on my sleep quality and quantity	Very ◯	Moderately ◯	Not very ◯	Not at all ◯

What are you most looking forward to learning or achieving by participating in this program?

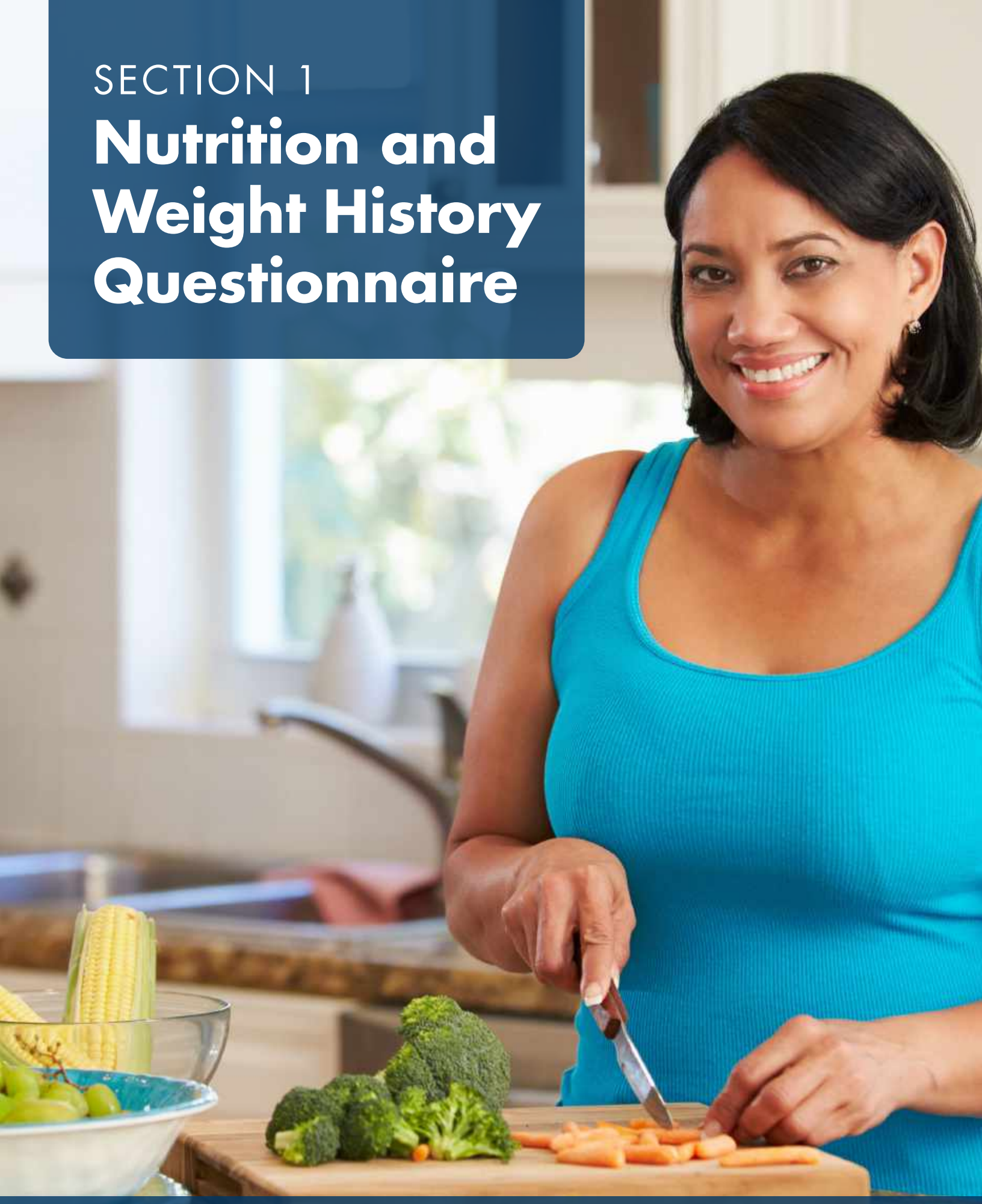
_____

_____

Initial: _____

SECTION 1

Nutrition and Weight History Questionnaire



Tell us about your preferences!

Please complete each section.

I prefer foods that are:

- ☐ Sweet
- ☐ Sour
- ☐ Salty
- ☐ Bitter
- ☐ Savory

My absolute must-have foods:

_____

_____

_____

Foods I can't stand:

_____

_____

_____

Who primarily shops for groceries?

- ☐ Me
- ☐ Spouse/Partner
- ☐ Other

Who primarily does the cooking?

- ☐ Me
- ☐ Spouse/Partner
- ☐ Other

Please describe your current average daily intake:

_____ ounces of water

_____ ounces of milk

_____ ounces of juice

_____ ounces of sugar sweetened beverages

_____ ounces of sugar-free soda

_____ ounces of caffeinated beverages

_____ ounces of alcohol

In a routine day, I typically eat:

- ☐ 3 meals
- ☐ 3+ snacks
- ☐ 1-2 meals
- ☐ 1-2 snacks
- ☐ mini meals all day "graze"
- ☐ 0 snacks

In an average week, the number of times I:

_____ order/dine out

_____ eat fast food

_____ grocery shop

_____ meal prep

_____ prepare meals at home

_____ use meal replacement or shakes

_____ participate in aerobic exercise

_____ participate in other forms of exercise

Initial: _____

24 Hour Food Recall

Please complete each section regarding what you had to eat and drink in the past 24 hours.

Breakfast

What time did you eat breakfast?

Where did you eat breakfast? *For example, home, work, car*

Is this a typical breakfast for you? *Yes or No (please describe)*

DESCRIBE WHAT YOU ATE:

Lunch

What time did you eat lunch?

Where did you eat lunch? *For example, home, work, car*

Is this a typical lunch for you? *Yes or No (please describe)*

DESCRIBE WHAT YOU ATE:

Dinner

What time did you eat dinner?

Where did you eat dinner? *For example, home, work, car*

Is this a typical dinner for you? *Yes or No (please describe)*

DESCRIBE WHAT YOU ATE:

Snacks

What time did you eat a snack?

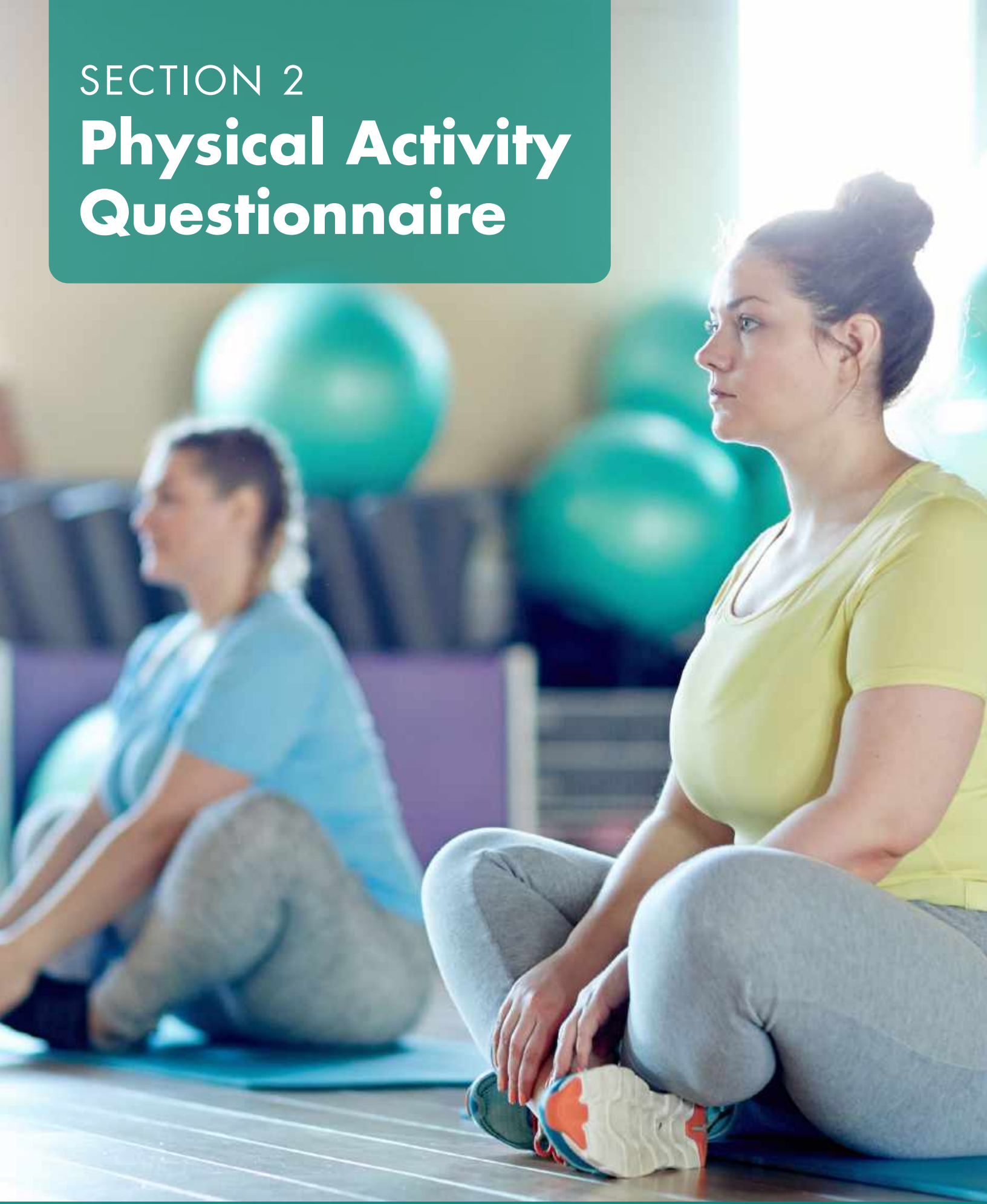
Where did you eat your snack? *For example, home, work, car*

Why were you eating? *Hunger, bordom, stress, etc.*

SNACKS

SECTION 2

Physical Activity Questionnaire



Tell us about your activity level.

Please complete each section.

Which most accurately describes your day-to-day activity level:

- ☐ Sedentary: I have a desk job and move around very little throughout the day. I routinely get less than 30 minutes of intentional exercise.
- ☐ Lightly active: I spend a large part of my day on my feet, and I get in 30 minutes of intentional exerise daily.
- ☐ Active: I spend a large part of my day doing something physical — examples include being a mailmain or waitress — AND I do intentional exercise every day equivalent to briskly walking for at least one hour and 45 minutes.
- ☐ Very Active: I spend most of my day doing something phsical — examples include carpenters or bike messengers — AND I do intentional exercise every day that is equivalent to briskly walking for at least four hourse and 15 minutes.

Please circle Y for yes or N for no if the following activities leave you feeling short of breath or winded:

(Y) (N)	Walking up one flight of stairs	(Y) (N)	Walking to and from your mailbox
(Y) (N)	Carrying groceries into your home	(Y) (N)	Walking an average city block

What activities/sports do you enjoy participating in? Please check all that apply!

☐ Walking	☐ Yoga	☐ Basketball
☐ Dancing	☐ Pilates	☐ Jogging
☐ Swimming	☐ Golf	☐ Strength training
☐ Skating	☐ Tennis	☐ Crossfit

Describe your current activity level in your own words:

_____

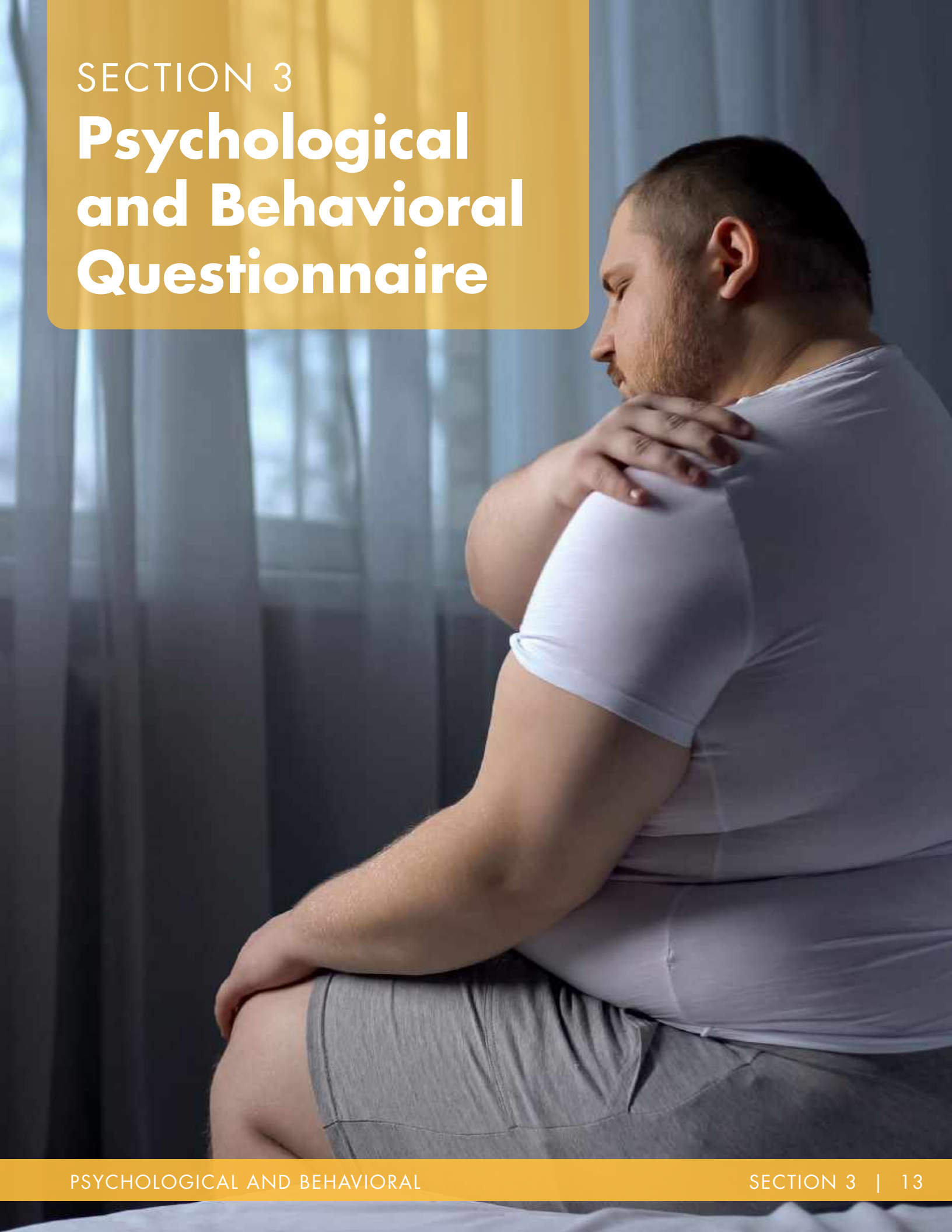
_____

_____

Initial: _____

SECTION 3

Psychological and Behavioral Questionnaire



PHQ-9 Generalized Health Screen

Please give a response for each question.

Over the last two weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite: being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3
10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?				
FOR IN OFFICE CODING				
	_____ +	_____ +	_____ +	_____
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

When did the symptoms begin?

_____

_____

TOTAL SCORE= _____

GAD-7 Generalized Anxiety Screen

Please give a response for each question.

Over the last two weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritated	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
8. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	0	1	2	3
FOR IN OFFICE CODING				
	_____ +	_____ +	_____ +	_____
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

When did the symptoms begin?

_____

_____

_____

_____

TOTAL SCORE= _____

Initial: _____

Audit-C and Cage Alcohol Use Screen

Please give a response for each question.

1. How often do you have a drink containing alcohol?

☐ Never ☐ 2-4 times a month ☐ 4 or more times a week

☐ Monthly or less ☐ 2-3 times a week

2. How many standard drinks containing alcohol do you have on a typical day?

☐ 1 or 2 ☐ 3 to 4 or less ☐ 5 to 6 ☐ 7 to 9 ☐ 10 or more

3. How often do you have six or more drinks on one occasion?

☐ Daily or almost daily ☐ Monthly ☐ Never

☐ Weekly ☐ Less than monthly

4. Have you ever felt you needed to cut down on your drinking?

☐ Yes ☐ No

5. Have people annoyed you by criticizing your drinking?

☐ Yes ☐ No

6. Have you ever felt guilty about drinking?

☐ Yes ☐ No

7. Have you ever felt you needed a drink first thing in the morning (eye-opener) to steady your nerves or to get rid of a hangover?

☐ Yes ☐ No

Initial: _____

DAST-10 Drug Use Screen

Please give a response for each question.

"Drug use" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (for example, paint thinner), tranquilizers (for example, Valium), barbiturates, cocaine, stimulants (for example, speed), hallucinogens (for example, LSD) or narcotics. The questions do not include alcoholic beverages.

These questions refer to drug use in the past 12 months. Please answer No or Yes.

1. Have you used drugs other than those required for medical reasponse?	☐ Yes	☐ No
2. Do you use more than one drug at a time?	☐ Yes	☐ No
3. Are you always able to stop using drugs when you want to?	☐ Yes	☐ No
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	☐ Yes	☐ No
5. Do you ever feel bad or guilty about your drug use?	☐ Yes	☐ No
6. Does your spouse (or parents) ever complain about your involvement with drugs?	☐ Yes	☐ No
7. Have you neglected your family because of your use of drugs?	☐ Yes	☐ No
8. Have you engaged in illegal activities in order to obtain drugs?	☐ Yes	☐ No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	☐ Yes	☐ No
10. Have you had medical problems as a result of your drug use (for example, memory loss, hepatitis, convulsions, bleeding, etc.)?	☐ Yes	☐ No

Initial: _____

Binge Eating Scale

Please give a response for each question.

Below are groups of statements about behavior, thoughts and emotional states. Please indicate which statement in each group best describes how you feel.

1.
☐ I don't feel self-conscious about my weight or body size when I'm with others.
☐ I feel concerned about how I look to others, but it normally does not make me feel disappointed with myself.
☐ I do get self-conscious about my appearance and weight which makes me feel disappointed in myself.
☐ I feel very self-conscious about my weight, and frequently I feel intense shame and disgust for myself. I try to avoid social contacts because of my self-consciousness.
2.
☐ I don't have any difficulty eating slowly in the proper manner.
☐ Although I seem to "gobble down" foods, I don't end up feeling stuffed because of eating too much.
☐ At times, I tend to eat quickly and then, I feel uncomfortably full afterward.
☐ I have the habit of bolting down my food without really chewing it. When this happens, I usually feel uncomfortably stuffed because I've eaten too much.
3.
☐ I feel capable of controlling my eating urges when I want to.
☐ I feel like I fail to control my eating more than the average person.
☐ I feel utterly helpless when it comes to feeling in control of my eating urges.
☐ Because I feel so helpless about controlling my eating, I have become very desperate about trying to get in control.

Initial: _____

Binge Eating Scale

Please give a response for each question.

Below are groups of statements about behavior, thoughts and emotional states. Please indicate which statement in each group best describes how you feel.

4.
☐ I don't have a habit of eating when I'm bored.
☐ I sometimes eat when I'm bored, but often I'm able to "get busy" and get my mind off food.
☐ I have a regular habit of eating when I'm bored, but occasionally, I can use some other activity to get my mind off eating.
☐ I have a strong habit of eating when I'm bored. Nothing seems to help me break the habit.
5.
☐ I'm usually physically hungry when I eat something.
☐ Occasionally, I eat something on impulse even though I really am not hungry.
☐ I have the regular habit of eating foods, that I might not really enjoy, to satisfy a hungry feeling even though physically, I don't need the food.
☐ Although I'm not physically hungry, I get a hungry feeling in my mouth that only seems to be satisfied when I eat a food, like a sandwich, that fills my mouth. Sometimes, when I eat the food to satisfy my mouth hunger, I then spit the food out so I won't gain weight.
6.
☐ I don't feel any guilt or self-hate after I overeat.
☐ After I overeat, occasionally I feel guilt or self-hate.
☐ Almost all the time I experience strong guilt or self-hate after I overeat.

Initial: _____

Binge Eating Scale

Please give a response for each question.

Below are groups of statements about behavior, thoughts, and emotional states. Please indicate which statement in each group best describes how you feel.

7.
☐ I don't lose total control of my eating when dieting even after periods when I overeat. ☐ Sometimes when I eat a "forbidden food" on a diet, I feel like I "blew it" and eat even more. ☐ Frequently, I have the habit of saying to myself, "I've blown it now, why not go all the way" when I overeat on a diet. When that happens I eat even more. ☐ I have a regular habit of starting strict diets for myself, but I break the diets by going on an eating binge. My life seems to be either a "feast" or "famine."
8.
☐ I rarely eat so much food that I feel uncomfortably stuffed afterward. ☐ Usually about once a month, I eat such a quantity of food, I end up feeling very stuffed. ☐ I have regular periods during the month when I eat large amounts of food, either at mealtime or at snacks. ☐ I eat so much food that I regularly feel quite uncomfortable after eating and sometimes a bit nauseous.
9.
☐ My level of calorie intake does not go up very high or go down very low on a regular basis. ☐ Sometimes after I overeat, I will try to reduce my caloric intake to almost nothing to compensate for the excess calories I've eaten. ☐ I have a regular habit of overeating during the night. It seems that my routine is not to be hungry in the morning but overeat in the evening. ☐ In my adult years, I have had week-long periods where I practically starve myself. This follows periods when I overeat. It seems I live a life of either "feast or famine."

Initial: _____

Binge Eating Scale

Please give a response for each question.

Below are groups of statements about behavior, thoughts and emotional states. Please indicate which statement in each group best describes how you feel.

10.
☐ I usually am able to stop eating when I want to. I know when "enough is enough."
☐ Every so often, I experience a compulsion to eat which I can't seem to control.
☐ Frequently, I experience strong urges to eat which I seem unable to control, but at other times I can control my eating urges.
☐ I feel incapable of controlling urges to eat. I have a fear of not being able to stop eating voluntarily.
11.
☐ I don't have any problem stopping eating when I feel full.
☐ I usually can stop eating when I feel full but occasionally overeat leaving me feeling uncomfortably stuffed.
☐ I have a problem stopping eating once I start and usually I feel uncomfortably stuffed after I eat a meal.
☐ Because I have a problem not being able to stop eating when I want, I sometimes have to induce vomiting to relieve my stuffed feeling.
12.
☐ I seem to eat just as much when I'm with others (family, social gatherings) as when I'm by myself.
☐ Sometimes when I'm with other people I don't eat as much as I want to eat because I'm self-conscious about my eating.
☐ Frequently, I eat only a small amount of food when others are present, because I'm embarrassed about my eating.
☐ I feel so ashamed about overeating that I pick times to overeat when I know no one will see me. I feel like a "closet eater."

Initial: _____

Binge Eating Scale

Please give a response for each question.

Below are groups of statements about behavior, thoughts, and emotional states. Please indicate which statement in each group best describes how you feel.

13.
☐ I eat three meals a day with only an occasional between-meal snack. ☐ I eat three meals a day, but I also normally snack between meals. ☐ When I am snacking heavily, I get in the habit of skipping regular meals. ☐ There are regular periods when I seem to be continually eating, with no planned meals.
14.
☐ I don't think much about trying to control unwanted eating urges. ☐ At least some of the time, I feel my thoughts are pre-occupied with trying to control my eating urges. ☐ I feel that frequently I spend much time thinking about how much I ate or about trying to eat anymore. ☐ It seems to me that most of my waking hours are pre-occupied by thoughts about eating or not eating. I feel like I'm constantly struggling not to eat.
15.
☐ I don't think about food a great deal. ☐ I have strong cravings for food but they last only for brief periods of time. I have days when I can't seem to think about anything else but food. ☐ Most of my days seem to be pre-occupied with thoughts about food. I feel like I live to eat.
16.
☐ I usually know whether or not I'm physically hungry. I take the right portion of food to satisfy me. ☐ Occasionally, I feel uncertain about knowing whether or not I'm physically hungry. At these times it's hard to know how much food I should take to satisfy me. ☐ Even though I might know how many calories I should eat, I don't have any idea what is a "normal" amount of food for me.

Initial: _____

Springfield clinic

A COMMUNITY OF CARING

Follow us on Instagram @SCBari