

Bariatric Intake Form

SECTION 1: PATIENT INFORMATION

First Name: _____ Last Name: _____
 Date of Birth (DOB): _____ dd / mm / yyyy Phone Number: _____
 Email Address: _____ Street Address: _____
 City: _____ Postcode: _____

SECTION 2: SURGEON INFORMATION

Surgeon's Name or Practice: _____ Street: _____
 City, State, ZIP: _____

SECTION 3: SURGICAL INFORMATION

Type of Bariatric Surgery Considered:

- Gastric Bypass (RNY)
 Gastric Sleeve
 Duodenal Switch (DS)
 SADI-S
 Not Sure
 Other

SECTION 4: WEIGHT HISTORY

How long have you been struggling with your weight?

- I do not remember a time when I was of average weight, including in childhood.
 I was of average weight as a child and became overweight as an adult.
 I became overweight after having children.
 I started struggling with weight after a specific life event (e.g., accident, marriage, job change).
 Other

Highest Adult Weight

Weight: _____ Age/Year at this Weight: _____

Lowest Adult Weight

Weight: _____ Age/Year at this Weight: _____

Current Weight and Height

Current Weight: _____ Current Height: _____

SECTION 5: BEHAVIORAL AND LIFESTYLE HISTORY

Previous Attempts for Weight Loss (Check all that apply):

- Low Fat
 Low Carb
 Ketogenic (Keto)
 Weight Watchers (WW)
 Paleo
 Intermittent Fasting
 Other

Exercise History (Check all that apply):

- Walking
- Running
- Swimming
- Gym Membership
- Yoga
- CrossFit
- Other

Current Exercise Routine:

Eating/Dietary Styles and Behaviors (Check all that apply):

- Skipping meals
- Overeating
- Night eating
- Junk food consumption
- Other

Coping Strategies Attempted (Check all that apply):

- Meal planning
- Food journaling
- Counseling
- Nutritionist support
- Cooking classes
- Other

SECTION 6: SUBSTANCE USE AND LEGAL HISTORY

Current or Past Use (Check all that apply):

- Alcohol
- Tobacco
- Marijuana
- Prescription drugs (e.g., painkillers, benzodiazepines)
- Illegal or Illicit Drugs (Specify below)
- None of the above

Specify Illegal or Illicit Drugs (If applicable):

Have you ever used tobacco products?

- Yes No

If yes, are you currently using tobacco?

- Yes No

How long have you been using tobacco products?

What type of tobacco products do you use (e.g., cigarettes, cigars, smokeless tobacco)?

How long has it been since you stopped using tobacco?

What type of tobacco products did you use (e.g., cigarettes, cigars, smokeless tobacco)?

Have you received substance use treatment?

Yes No

If yes, please specify the types of treatment (Check all that apply):

- Detoxification
- Individual Therapy/Counseling
- Group Therapy (e.g., AA/NA)
- Intensive Outpatient Treatment
- Residential Treatment

Do you currently use any substances, including tobacco or marijuana?

Yes No

If yes, please specify substance and frequency of use:

For substances you no longer use, how long have you been substance-free?

Do you use medical marijuana prescribed by a medical provider?

Yes No

If yes, what is the purpose of its use?

Have you discussed potential cross addiction risks with your provider?

Yes No

If yes, please provide details:

Have you experienced any legal issues related to substance use?

- Arrests
- Convictions
- DUI
- Probation/Parole
- None of the above

If yes, please specify:

Do you have any current pending legal charges?

Yes No

If yes, please describe:

Additional Comments on Substance Use or Legal History

SECTION 7: MENTAL HEALTH AND ABUSE HISTORY

Have you ever been diagnosed with a mental health condition?

Yes No

If yes, please specify:

Previous Mental Health Treatment - Check all that apply:

- Therapy/Counseling
- Medication
- Inpatient Psychiatric Care
- None
- Other

Abuse History - Check all that apply:

- Physical Abuse
- Emotional Abuse
- Sexual Abuse
- Never experienced abuse

If you are comfortable, please provide details:

Neglect History - Check all that apply:

- Childhood neglect
- Lack of emotional support
- Never experienced neglect

Additional information (if comfortable):

SECTION 8: PHYSICAL HEALTH AND MEDICAL HISTORY

Do you have any known drug allergies?

- Yes No

If yes, please explain:

Please describe any current medical conditions:

Please list all current medications:

Describe any chronic pain or if you use any adaptive devices:

Do you have a disability that makes it hard to be active?

- Yes No

If yes, please explain:

SECTION 9: RISK ASSESSMENT AND COPING SKILLS

Health-Related Risk-Taking Behaviors (Check all that apply):

- Ignoring doctor's orders
- Medication misuse
- Impulsive health behaviors
- None

If yes, what coping skills have you applied to manage this behavior?

SECTION 10: LIFE STRESSORS AND SUPPORT SYSTEM

Current Life Stressors (Check all that apply):

- Caregiving for a loved one
- Death of a loved one
- Job loss
- Financial issues
- Relationship problems
- None
- Other

Support System (Check all that apply):

- Family
- Friends
- Religious Community
- Co-workers

SECTION 11: COGNITIVE AND EDUCATIONAL HISTORY

Highest Level of Education Completed (Check one):

- High School
- Some College
- Bachelor's Degree
- Graduate Degree
- Other

Learning Preferences (Check all that apply):

- Reading
- Listening
- Seeing
- Doing

SECTION 12: SPIRITUAL AND RELATIONSHIP HISTORY

Spiritual Beliefs - Select one:

Atheist Religious Spiritual Other

Current Marital Status - Select one:

Single
 Married
 Divorced
 Committed Relationship
 Other

Do you have any children?

Yes No

If yes, please specify number and ages:

SECTION 13: MOTIVATION AND EXPECTATIONS

Please provide your goal weight or BMI: _____

Why do you want to have bariatric surgery?

How do you hope your life will be different after surgery?

Do you know anyone who has had bariatric surgery?

Yes No

If yes, what was their experience like?

SECTION 14: SIGNATURE AND ACKNOWLEDGMENT

I confirm that the answers provided are truthful to the best of my knowledge.

Patient Signature: _____

Name: _____

Date: _____ dd / mm / yyyy