Mark S. DeBord, LCSW, LLC
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Name: _____ Date:_____ Case #: _____

History and Description of Eating Habits

How tall are you? _____ How much do you weigh currently? _____

What do you think are the main contributors to your weight? (e.g., genetics, poor food choices, large portions, meal/snack patterns, emotional eating, time constraints, lack of exercise, smoking cessation, medications, menopause, other medical conditions, etc.)

What are the primary reasons for your seeking to have bariatric surgery? In other words, how might you benefit from losing weight?

How did you become interested in bariatric surgery?

Which type bariatric surgery are you considering?

Who do you expect to be your biggest supporter (s)?

When was the first time you really became aware that you were overweight and needed to do something about it? (please identify a general date and briefly describe)

What might you have weighed at 18 years old? _____

What was your highest weight? _____ When was that? _____

Please outline your weight history from the time you were 18 y/o or the time you first became concerned about your weight by listing significant dates and/or events.
With EACH date and/or event please note as much of the following as possible: what you think most contributed to the weight gain, what you did to attempt to lose weight, how much weight may have been lost (with beginning and ending weight), what type exercise in which you may have engaged, and how long you maintained that weight loss.

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Food Preference and Sources

Do you have a certain type of food(s) that you consider your "weakness(es)"?

How often do you drink sweetened beverages like soda, juice, sports drinks, sweet tea, sweetened coffee, etc.?

Who shops for you and prepares most of your food?

Where do you get meals when you are at school/work?

How often do you eat at restaurants? _____ times per week

How often do you eat "fast food"?

Do you find that you have times when you will eat continuously?

_____ Yes ____ No (If yes) When is this most likely to happen?

Do you get up in the night and eat? _____ Yes ____ No
Do you eat right before going to bed? _____ Yes ____ No
Do you hide food or eat hoping no one will see or know? ____ Yes ____ No
After overeating, do you tend to feel quite guilty – bad about yourself?
_____Yes ____ No

Emotional Eating	
How many times per week do you eat in response to negative emotions (depressed, anxious, worried, stressed)?	Per week
Do you find that you use food as a coping mechanism? (suggested answers: yes, no or not sure)	
How many times per week do you find that you eat when you are bored or eating mindlessly while watching TV?	Per week
Are your current emotions or stressors contributing to your weight by causing you to eat more? – yes or no	
Do you feel that eating in response to emotions contributes significantly to your weight or makes it difficult to lose weight? – yes or no	

What does a typical day look like in terms of your eating behavior? In other words, what would you eat for breakfast, lunch, dinner, when might you snack, etc.?

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What does a typical day of overeating look like?

Does a typical week day or work day look different than a weekend day? If so, how?

Is there anything else that you think important to add concerning your eating history or habits?

What do you know about the surgery in terms of what the surgeon will actually be doing?

How do you think you will be able to eat when you are back on solid food following surgery?

Thank you for completing this form.

Please remember to bring this completed form with you to your appointment.