

Remedy Counseling, LLC Scales for Bariatric Assessment

Beck's Depression Inventory:

Check the box with the best answer

1.

- 0 I do not feel sad.
- 1 I feel sad
- 2 I am sad all the time and I can't snap out of it.
- 3 I am so sad and unhappy that I can't stand it.

2.

- 0 I am not particularly discouraged about the future.
- 1 I feel discouraged about the future.
- 2 I feel I have nothing to look forward to.
- 3 I feel the future is hopeless and that things cannot improve.

3.

- 0 I do not feel like a failure.
- 1 I feel I have failed more than the average person.
- 2 As I look back on my life, all I can see is a lot of failures.
- 3 I feel I am a complete failure as a person.

4.

- 0 I get as much satisfaction out of things as I used to.
- 1 I don't enjoy things the way I used to.
- 2 I don't get real satisfaction out of anything anymore.
- 3 I am dissatisfied or bored with everything.

Beck's Depression Inventory:

5.

- 0 I don't feel particularly guilty**
- 1 I feel guilty a good part of the time.**
- 2 I feel quite guilty most of the time.**
- 3 I feel guilty all of the time.**

6.

- 0 I don't feel I am being punished.**
- 1 I feel I may be punished.**
- 2 I expect to be punished.**
- 3 I feel I am being punished.**

7.

- 0 I don't feel disappointed in myself.**
- 1 I am disappointed in myself.**
- 2 I am disgusted with myself.**
- 3 I hate myself.**

8.

- 0 I don't feel I am any worse than anybody else.**
- 1 I am critical of myself for my weaknesses or mistakes.**
- 2 I blame myself all the time for my faults.**
- 3 I blame myself for everything bad that happens.**

Beck's Depression Inventory:

9.

- 0 I don't have any thoughts of killing myself.**
- 1 I have thoughts of killing myself, but I would not carry them out.**
- 2 I would like to kill myself.**
- 3 I would kill myself if I had the chance.**

10.

- 0 I don't cry any more than usual.**
- 1 I cry more now than I used to.**
- 2 I cry all the time now.**
- 3 I used to be able to cry, but now I can't cry even though I want to.**

11.

- 0 I am no more irritated by things than I ever was.**
- 1 I am slightly more irritated now than usual.**
- 2 I am quite annoyed or irritated a good deal of the time.**
- 3 I feel irritated all the time.**

12.

- 0 I have not lost interest in other people.**
- 1 I am less interested in other people than I used to be.**
- 2 I have lost most of my interest in other people.**
- 3 I have lost all of my interest in other people.**

Beck's Depression Inventory:

13.

- 0 I make decisions about as well as I ever could.**
- 1 I put off making decisions more than I used to.**
- 2 I have greater difficulty in making decisions more than I used to.**
- 3 I can't make decisions at all anymore.**

14.

- 0 I don't feel that I look any worse than I used to.**
- 1 I am worried that I am looking old or unattractive.**
- 2 I feel there are permanent changes in my appearance that make me look unattractive**
- 3 I believe that I look ugly.**

15.

- 0 I can work about as well as before.**
- 1 It takes an extra effort to get started at doing something.**
- 2 I have to push myself very hard to do anything.**
- 3 I can't do any work at all.**

16.

- 0 I can sleep as well as usual.**
- 1 I don't sleep as well as I used to.**
- 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.**
- 3 I wake up several hours earlier than I used to and cannot get back to sleep.**

Beck's Depression Inventory:

17.

- 0 I don't get more tired than usual.**
- 1 I get tired more easily than I used to.**
- 2 I get tired from doing almost anything.**
- 3 I am too tired to do anything.**

18.

- 0 My appetite is no worse than usual.**
- 1 My appetite is not as good as it used to be.**
- 2 My appetite is much worse now.**
- 3 I have no appetite at all anymore.**

19.

- 0 I haven't lost much weight, if any, lately.**
- 1 I have lost more than five pounds.**
- 2 I have lost more than ten pounds.**
- 3 I have lost more than fifteen pounds.**

20.

- 0 I am no more worried about my health than usual.**
- 1 I am worried about physical problems like aches, pains, upset stomach, or constipation.**
- 2 I am very worried about physical problems and it's hard to think of much else.**
- 3 I am so worried about my physical problems that I cannot think of anything else.**

Remedy Counseling, LLC Scales for Bariatric Assessment

Beck's Depression Inventory:

21.

- 0 I have not noticed any recent change in my interest in sex.**
- 1 I am less interested in sex than I used to be.**
- 2 I have almost no interest in sex.**
- 3 I have lost interest in sex completely.**

Remedy Counseling, LLC Scales for Bariatric Assessment

Beck Anxiety Scale:

Circle the best answer:

	Not At All	Mildly but it didn't bother me much.	Moderately - it wasn't pleasant at times	Severely - it bothered me a lot
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding/racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky / unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot/cold sweats	0	1	2	3
Column Sum				

BES Questionnaire

Fill in the dot next to the best answer:

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 afterwards.
- 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 to control my eating urges when I want to.
- I feel like I have failed 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.

BES Questionnaire

4.

- I don't have the 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.

BES Questionnaire

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 afterwards.
- 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.

BES Questionnaire

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."

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.

BES Questionnaire

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 persons, 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 very 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."

13.

- I eat three meals a day with only an occasional between meal snack.
- I eat 3 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 not 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.

BES Questionnaire

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.

BES Questionnaire/Body Image

1. I don't feel self-conscious about my weight or body size when I'm with others.
2. I feel concerned about how I look to others, but it normally does not make me feel disappointed with myself.
3. I do get self-conscious about my appearance and weight which makes me feel disappointed in myself.
4. 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.
5. I don't feel self-conscious about my weight or body size when I'm with others.
6. I feel concerned about how I look to others, but it normally does not make me feel disappointed with myself.
7. I do get self-conscious about my appearance and weight which makes me feel disappointed in myself.
8. 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.

Rosenburg Self-Esteem Scale

Fill in bubble that best answers the question:

STATEMENT		Strongly Agree	Agree	Disagree	Strongly Disagree
1.	I feel that I am a person of worth, at least on an equal plane with others.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.	I feel that I have a number of good qualities..	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3.	All in all, I am inclined to feel that I am a failure.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.	I am able to do things as well as most other people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5.	I feel I do not have much to be proud of.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.	I take a positive attitude toward myself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7.	On the whole, I am satisfied with myself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8.	I wish I could have more respect for myself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9.	I certainly feel useless at times.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10.	At times I think I am no good at all.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Do you have any Food or Drug allergies? Yes No If yes, explain:

Have you ever been diagnosed with a Mental Health Issue? (Example: Depression, Anxiety, etc.). Yes No If yes,

What was/is your diagnosis?

When were you first diagnosed?

Who diagnosed you (Example: Primary Care Physician, Psychiatrist, Therapist, etc.)?

Have you ever taken psychotropic medication(s) for a mental health diagnosis? Yes No If yes, explain:

Name of provider prescribing your psychotropic medication(s):

Length of time the provider has prescribed your psychotropic medications:

When was the last time you had your psychotropic medication(s) adjusted by your provider?

How often do you see your provider for your psychotropic medication(s)?

Name and dosage(s) of your current psychotropic medication(s):

How long have you been on these current psychotropic medication(s)?

Are you still taking mental health medication? Yes No

If yes, explain:

Are your current psychotropic medication(s) helpful for your symptoms? Yes No If yes, explain:

How the psychotropic medication(s) help with your symptoms:

Are experiencing mental health symptoms with your current psychotropic medication(s)? Yes No If yes, explain:

What symptoms are you experiencing?

Has your provider made recommendations for other mental health services to help with your mental health stability? Yes No If yes, explain:

Are you currently complying with your doctors recommendations?

Yes No N/A If yes, explain the services you are engaging in.

Have you ever taken psychotropic medications for a Mental Health Diagnosis in the past? Yes No If yes, explain:

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Name of past provider(s) who prescribed psychotropic medications to you:

List all name(s) and dosage(s) of past psychotropic medication(s) prescribed by past providers:

**Page |
18**

Did you ever discharge/stop your psychotropic medication(s) or has your doctor ever discharged your psychotropic medication(s)?

Yes No **If yes,**

List names and dosage(s) of past psychotropic medication(s) that were discharged/stopped by you or your doctor:

List how long you took past psychotropic medication(s) before they were discharged/stopped:

List why you or your doctor discharged/stopped your psychotropic medication(s). Example: stable without medication(s), side effects, medication stopped working, diagnosis changed indicating a discharge of a medication(s) or using coping skills instead of medication(s):

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Briefly explain why and when your psychotropic medications were discontinued/discharged (stability, side effects, resolved mental health symptoms and no longer need medication, using coping skills instead of medications, stable without medication, side effects, diagnosis change/addition, etc.):

Page |
19

Did you ever re-start or try a different medication(s) after stopping your previous psychotropic medication(s)?

Yes **No** **If yes,**

Please provide approximate list of dates of all previous episodes where you stopped and re-started psychotropic medication(s):

List names and dosages psychotropic medication(s) that were discharged or stopped by your doctor:

Provide reason psychotropic medication(s) were re-started or you changed to a new medication through your doctor:

List any psychotropic medication episodes of any increases or decreases in the medication(s) to achieve mood stability through your doctor:

Explain length of time, name, and dosages of stopping and re-starting psychotropic medication(s):

Explain length and time of taking a new medication(s) with name and dosage(s) of the new psychotropic medication(s) through your doctor:

List any mental health diagnosis change or additional mental health diagnosis addition throughout your lifetime:

List any necessary psychotropic medication(s) that needed to be discharged, adjusted, or added due to a mental health diagnosis change or an added mental health diagnosis:

Did you ever stop taking your psychotropic medications without consulting with your doctor?

Yes No **If yes,**

List names and dosages of past psychotropic medication(s), dosage, and how long you took the medication(s) before you stopped the medication on your own:

List each medication(s) and dosage and reason for self-discharging the psychotropic medication(s):

List any psychotropic medication (name and dosage) prescribed by your doctor that you decided not to take:

Briefly explain why you did not want to take the prescribed psychotropic medication(s):

Have you had any medication changes in the past 6 months?

Yes **No** **If yes,**

List all medication changes (to include increases in current medications, discharge of a medication(s) or addition to current medication(s) etc.):

Briefly explain the reason for the psychotropic medication adjustment or addition to current psychotropic medications:

Do you feel like your symptoms are in remission due to your psychotropic medication in the past 6 months? Yes No **If yes, Briefly explain what symptoms have been resolved with your psychotropic medication(s):**

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Explain other mental health supports you are currently utilizing (individual therapy, marriage therapy if applicable, group therapy, online support groups, etc.):

List support(s):

Page |
22

How long you have been using these support(s) past/present?

What benefits are you getting from your current support(s) past/present:

Do you feel you are “stable”, and that your symptoms are stable with current psychotropic medication(s) & support(s)? Yes No

If yes, explain what symptoms have reduced or stopped due to psychotropic medication(s) and supports?

Have you experienced any mental health symptoms in the past 6 months?

Yes No **If yes,**

Briefly explain symptom you are struggling with:

What plan(s) are you implementing to get your symptoms stable (medication change, individual therapy, et.):

Briefly explain any mental health symptoms you have struggled with over the past 6 months and are currently working on with psychotropic medication(s) and support(s):

Are you currently engaged in Mental Health Therapy with a therapist?

Yes **No**

If yes, please

List provider(s) name:

How long you have been seeing current provider(s):

List general issues working on in current treatment(s):

Have you ever engaged in any type of Mental Health Therapy in the past?

Yes **No**

If yes, please list provider(s) name:

How long did you see this provider(s)?

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List all past episodes of past treatment(s) (Example: individual treatment from 1/19 to 3/20, again in 3/21 until present time, family therapy for 2 years from 4/17 to 4/19 etc.):

Reason for treatment(s):

Page |
24

List mental health diagnosis and/or life stressors that have led you to engage in Mental Health Therapy presently: