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Lap Band Psychological Consultation

Beginning the process for Lap-Band Weight Loss Surgery can often be confusing at times and we would like our clients to fully understand the procedures we must follow to ensure (1) you can obtain your goal of a healthier lifestyle and (2) your insurance will have all the information needed to authorize coverage for your surgical procedure.

The following is an outline of the Lap-Band Weight Loss Surgery Consultation process:

- You have had a consultation with a surgeon who specializes in weight loss surgeries.
- After this consultation, you were directed to contact a behavioral health specialist to obtain a psychological consultation.
- Usually these evaluations are divided into two hour-long sessions, one week apart, and will include:
  - Initial Assessment- a brief interview with a counselor and some paper and pencil questionnaires/ inventories to be completed by the client.
  - Follow-up visit- a more in depth interview with the counselor and review of your testing results.
- Upon completion of interviews and testing, we will prepare your psychological evaluation and send a finished report to your surgeon.
- Each client's report is quite detailed and requires at least **3 weeks** from your second visit with the counselor to reach your surgeon and/or their staff.

Please contact our office with a detailed message through e-mail, our website or by phone with any questions or concerns you may have regarding this process.

Thank you,

Debra Lee Carr, LPC

Debra Lee Carr, LPC Counseling and Consulting, LLC

Intake Form

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form **completely** and bring with you to your first session. **Items marked with an * must be completed.**

*Legal Name: ____

(Last) (First) (Middle Initial) (Maiden)

*Birth Date: _____/_____/_____ Age: ____ *Gender: ☐M ☐F *Social Security #: _____-_____-______

Preferred Name: ____

*Parent/guardian Name
(if under 18 years): ____

(Last) (First) (Middle Initial)

*Marital Status: ☐Never Married ☐Married ☐Divorced ☐Widowed ☐Separated ☐Domestic Partnership

*Address: ____

(Street and Number) (PO Box) (City) (State) (Zip)

*Home Phone: (_____) _____-______ May we leave a message? ☐Yes ☐ No

*Cell Phone: (_____) _____-______ May we leave a message? ☐Yes ☐ No

E-mail: ______________________________ May we email you? ☐ Yes ☐ No

Please note: Email correspondence is not considered to be a confidential medium of communication.

Occupation: ____________________ Employer: ______________________________ Are you a student? ☐Y ☐N

Any other family members/ friends seen here: ____

Please list any children/age: ____

____

Referred by (if any): ____

*Primary Care Doctor: ______________________________ PCP Phone: (_____)_____-______

***Emergency Contact:** **In case of an Emergency**, we will need to contact a local friend or relative.
Please provide the name, relationship and a phone number for this emergency contact.

____

(Name) (Relationship to client) (Phone Number)

***Primary Insurance Information (PLEASE PRESENT YOUR INSURANCE CARD TO RECEPTIONIST. A COPY WILL BE KEPT IN YOUR FILE.)**

Name of Insurance: ______________________________ Subscriber's Legal Name: ______________________________

Subscriber's Social Security #: ____________________ Birth Date: ____/____/_____ Gender: ☐M ☐F

Subscriber's ID #: ______________________________ Group #: ____________________

Client's Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other

Secondary Insurance Information (if applicable)

Name of Insurance: ____________________ Subscriber's Legal Name:____________________

Subscriber's Social Security #: ______________ Birth Date: ___/___/_____ Gender: ☐M ☐F

Subscriber's ID #: ____________________ Group #: ______________

Client's Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other

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Please initial each of the following statements, sign and date at the bottom:

***COUNSELING SERVICES APPOINTMENT POLICY**

________All clients are expected to attend appointments as scheduled. It is recognized that occasionally circumstances occur that require missing an appointment. It is the client's responsibility to call to reschedule counseling sessions. Clients will be charged a $60.00 fee for any missed appointment and if they fail to cancel an appointment at least one business day in advance (i.e., cancel Monday appointments by 5 p.m. the preceding Friday; and Tuesday through Friday appointments must be canceled 24 hours in advance).

***CONFIDENTIALITY**

________NO information about your counseling will be released to anyone without your prior WRITTEN authorization, except in the following situations:

1. When there is risk of imminent harm to yourself or another person, counselor is legally and ethically bound to do whatever is necessary to protect life.
2. When a court of law orders information to be released, counselor is legally bound to comply.
3. When there is reasonable cause to suspect that a child, elderly person, or mentally incompetent person is being abused, neglected, or exploited, counselor is legally bound to report such abuse.
4. If you are involved in a medical emergency, information may be given to medical personnel.
5. If you participate in group counseling, as a member of the group you will be expected to commit to maintaining the confidentiality of that group, including keeping secret the identities of the other members of the group.

Counselors retain the privilege to consult with peers about clients for treatment and/or training purposes, but no identifying information will be used in order to protect client's confidentiality. I understand the limits to confidentiality stated above, and I accept them as part of the conditions of participating in counseling.

***ACKNOWLEDGEMENT OF PRIVACY PRACTICES**

________I acknowledge that I am aware I can request a copy of the *Notice of Privacy Practices*, which describes this agency's methods for protecting the privacy of my health information that is used in providing service to me.

***FINANCIAL POLICY**

________1. INSURANCE: Counseling services are provided directly to the client and not to an insurance company. Thus, you are expected to pay all co-pay and deductible amounts at time of service. I understand that it is my responsibility to check with my insurance representative to make sure that this service is covered by my policy. I also understand this is not a guarantee of coverage and I will be responsible for any balance my insurance company denies or deems not medically necessary.

________2. SPECIAL NEEDS: Special needs are understood by this office. It may be necessary to set up a payment plan for a patient requiring extensive treatment. If this situation is necessary for you, please bring this to our attention as soon as possible.

***I WOULD LIKE TO REQUEST SERVICES FOR MYSELF AND CONSENT TO PARTICIPATE IN COUNSELING**

________Clients will be treated with respect and dignity, especially with regard to age, color, culture, disability, ethnic group, gender, race, religion, sexual orientation, marital status, or socioeconomic status. I understand that participation in counseling is strictly voluntary. I have asked for any needed clarification of the conditions mentioned above, I am satisfied with the explanations, and I agree to abide by these conditions. I consent to participate in counseling and I understand that I may withdraw this consent at any time.

* ______________________ ______________________ * ____________

(Client Signature) (Witness Signature) (Date)

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*Client Questionnaire

Your cooperation in completing this questionnaire will help us serve you better

Please answer each item carefully.

Last Name: **First Name:** **Middle Initial:**

Age	**Gender**	**Employed**	**If Yes, # hours/week**	**Place of Employment?**	**Live With**
	☐Male	☐Yes			☐Alone ☐Roommate ☐Family
______	☐Female	☐No	______	______	☐Significant Other

Ethnicity ☐Asian/Asian American ☐Native American ☐Multi-racial American ☐Black/African American ☐White/Non-Hispanic American ☐International Student: What country? ______ ☐Latino/Hispanic American ☐Other American

Sexual Orientation ☐Heterosexual ☐Gay Man ☐Transgender ☐Lesbian ☐Bisexual

Relationship Status ☐Single ☐Widowed ☐Divorced ☐Separated ☐Married ☐Partnered ☐In committed dating relationship

Please list anyone who may attend sessions with you and their age: ______

Religious affiliation, if any (optional) ______

Have you previously used our services? ☐Yes ☐No When? ______

Who referred you? ______

May we call that person to let them know you came to see us? ☐Yes ☐No

Have you previously received any psychological, psychiatric, or counseling services?
☐Yes
☐No If yes, please describe: ______

Do you have any chronic medical conditions, including pain or any disabilities?
☐Yes
☐No If yes, please describe: ______

Please list all current medications: ______

Please briefly describe what you see as the problem for which you seek counseling at this time: ______

Please check all of the following items which are concerns at this time, and circle the most important.

__Abortion	__Discrimination	__Irresponsibility	__Romantic relationship
__Abuse- physical/sexual	__Divorce, separation	__Legal problems	__Self-injury, mutilation
__Abuse- emotional/neglect	__Eating problems/ disorder	__Loss of pleasure in activities	__Self-neglect, poor self-care
__Academic functioning	__Emptiness	__Loneliness, no friends	__Sexual assault
__Aggression or anger	__Family relationships	__Marital Problems	__Sexual concerns
__Alcohol and/ or drug use	__Fatigue, tiredness	__Memory Problems	__Sexual harassment
__Anger, arguing	__Fearing Failure	__Mood Swings	__Sexual orientation
__Anxiety, panic attacks	__Fears, phobias	__Motivation, laziness	__Shame
__Appetite loss	__Financial problems	__Obsessive thoughts	__Shyness
__Attention, focus	__Friendships	__Over-responsible for others	__Sleep problems
__Body image	__Gambling	__Over-sensitive to rejection	__Social/dating problems
__Career concerns	__Grief	__Panic attacks	__Social isolation
__Childhood issues (yours)	__Guilt	__Perfectionism	__Smoking, tobacco use
__Children, parenting concerns	__Health, medical concern	__Peer relationships	__Stress
__Chronic pain	__Hallucinations	__Pregnancy	__Suspiciousness
__Compulsive behaviors	__Identity issues	__Procrastination	__Suicidal thoughts
__Decision making	__Impulsive, out of control	__Repeated troubling thoughts	__Thought disorganization
__Depression, sadness, crying	__Independence from parents	__Religious/spiritual concerns	__Worthless feelings

I use alcohol:	**I use recreational drugs (pot, pills, inhalants, ect):**	**My use of alcohol &/or drugs has resulted in:**	
__Never	__Never	__Traffic violations	__Fight with friends
__Less than once per week	__Less than once per week	__Academic problems	__Blackouts
__About once per week	__About once per week	__Ruined relationships	__Arrest
__More than once per week	__More than once per week	__Problems on the job	__Problems at home
__Most every day	__Most every day	__Health problems	__Marital problems

How much tobacco do you use daily? **How interested are you in quitting (circle one)?** No interest Low Med High

I have tried to control my weight with:	**I have thought about or tried to:**	**Recent stresses:**	
__Vomiting	__Harm myself - past	__Death of someone close	__Financial difficulties
__Laxatives	__Harm myself - present	__Relationship began or ended	__Change in sleeping habits
__Not eating	__Harm another person - past	__Major move	__Conflict with someone close
__Diet pills	__Harm another person - present	__Employment change	__Illness, health concerns
__Excessive exercise	**If attempted to harm self in the past, how many times** ________		
__Other			

I have difficulty:

__Expressing my emotions __Controlling my anger __Handling stress __Making friends __Accepting myself __Functioning at work/school

Family members/others who are important to you: Relation/Age

____

____

____

____

My family and I are:

__ In a satisfactory relationship
__ Unable to talk about personal issues
__ Not emotionally close
__ In an unsatisfactory relationship

Family History	**Family member involved**
__Anxiety	______
__Depression	______
__Alcohol abuse	______
__Drug abuse	______
__Gambling problem	______
__Eating Disorder	______
__Suicide	______
__Self-harm	______
__Abuse	______
__Other	______

Please circle all hours you are available for counseling appointments.

Monday	9	10	11	12	1	2	3	4	5	6
Tuesday	9	10	11	12	1	2	3	4	5	6
Wednesday	9	10	11	12	1	2	3	4	5	6
Thursday	9	10	11	12	1	2	3	4	5	6
Friday	9	10	11	12	1	2	3	4	5	6

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WEIGHT LOSS QUESTIONAIRE:

1. Are you pregnant or planning to become pregnant?

2. How long have you struggled with weight?

___ since childhood ___ since teen years ___ all adult life ___ the last few years

3. How many times have you tried to lose weight?

___ none ___ once ___ a few ___ too many to count

4. What have you tried? Check all that apply

___ dieting on your own ___ dieting in group like weight watchers ___ support group like overeaters anonymous

___ with guidance of a doctor or nutritionist ___ hospital program ___ weight loss medication ___ counseling

___ none of the above ___ other - describe ______________________________

5. How often do you exercise?

___ never or almost never ___ 1 - 2 times a week ___ 3 - 4 times a week ___ 5 - 6 times a week

___ every day or almost every day

6. How has weight affected your identity?

___ embarrassment ___ feel powerless ___ feel stigma from society ___ health issues

___ other - explain ______________________________

7. During the past year has weight affected...

___ daily activities like bathing, cooking, getting dressed ___ social activities ___ physical activity

___ pain and discomfort ___ other - explain ______________________________

8. Do you have any of the following medical conditions:

    ___ bleeding or clot disorder ___ binge eating ___ heart problems

    ___ Depression ___ drug or alcohol use/abuse ___ psychosis

    ___ other mental or emotional concerns - explain ______________________________

    ___ any previous counseling or hospitalizations for mental or emotional concerns? Describe: ___

    ____

    ___ other physical health concerns - explain ______________________________

___ any previous counseling or hospitalizations for physical health concerns? Describe: ________

____

9. When you socialize with family and friends, is the focus usually eating?

10. Do you feel like you would have support from family and friends if you had weight loss surgery?

11. Is there a history of weight problems in your family?

    ___ parents

    ___ grandparents

    ___ siblings

    ___ spouse

    ___ children

12. What are your reasons for wanting weight loss surgery?

    ___ Health - Describe Obesity related problems:

    ___ Quality of life - Describe these issues:

    ___ Appearance

    ___ Other:

13. For the Doctor's appointments, counseling, meal preparation, exercise associated with weight loss surgery ...

    ___ Do you have time for all of this?

    ___ Are you willing to commit to this process?

13. Please add any other information you would like for the Counselor to know?