Cynthia Turner, Ph.D.
Licensed Psychologist
7505 Waters Ave., Suite E-2
Savannah, GA 31406
Office (912) 352-8658 Fax (912) 356-5492

We extend a warm welcome to you, our new patient. The quality of care we provide to our patients is important to us.

It is our policy to collect the total charge of $400.00 for the evaluation and report at the time of service excepting cases in which some managed care insurance policies apply. When you call for scheduling, these issues will be further discussed with you. Please note fees are subject to change.

WE GLADLY ACCEPT MASTERCARD, VISA, CASH, CASHIERS CHECK, OR MONEY ORDER (NO PERSONAL CHECKS, AMERICAN EXPRESS OR DISCOVER). Included in the fee: administration of the MMPI-2-RF or MBMD test, clinical interview and evaluation, and a written psychosocial evaluation report.

We are located at 7505 Waters Ave. Suite E-2, in the business complex Park South. Park South is located between Eisenhower Drive and Mall Blvd. across the street from the Enmark gas station. Directions to our office is attached. This office is not handicap accessible.

We have another location that is handicap accessible. That location is 315 Commercial Dr., Suite C-3, in the business complex Regency Executive Plaza. Regency Executive Plaza is located next to Fox and Weeks Funeral Home. Directions to this office is attached.

We have an alarm entry system set up for patient confidentiality; therefore you will need to knock on the office door for admittance upon your arrival.

PLEASE NOTE: ANY CANCELLATIONS OR CHANGE IN THE SCHEDULING OF YOUR APPOINTMENT WILL REQUIRE A 24 HOUR NOTICE. YOUR TIME IS RESERVED FOR YOU AND YOU ONLY. WE DO NOT DOUBLE-BOOK OR OVERBOOK APPOINTMENTS. CANCELLATIONS PROBABLY WILL RESULT IN A SUBSTANTIAL DELAY WITH REGARD TO YOUR EVALUATION AND SUBSEQUENTLY TO THE SCHEDULING OF YOUR SURGERY.

Please feel free to call the office at any time if you have questions, concerns or issues regarding the evaluation process and/or recommendations. Dr. Turner or Hyacinth Townsend will be glad to assist you.

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DIRECTIONS TO DR. CYNTHIA TURNER'S OFFICE
PARK SOUTH OFFICE COMPLEX
7505 WATERS AVE., SUITE E-2
SAVANNAH, GA 31406

FROM INTERSTATE 16 AND LYNES PARKWAY (516), MERGES INTO DERENNE AVE.

TURNER RIGHT ON WATERS AVE.

DRIVE APPROXIMATELY TWO MILES

AFTER CROSSING THE EISENHOWER INTERSECTION, LOOK FOR PARK SOUTH OFFICE COMPLEX, 7505 WATERS AVE. ACROSS FROM THE ENMARK GAS STATION.

TURN RIGHT INTO THE PARKING LOT, THEN LEFT TOWARDS BUILDING E.

THE OFFICE IS UPSTAIRS TO THE LEFT, SUITE E-2

FROM INTERSTATE 95, TAKE 204 TOWARDS SAVANNAH, WHICH MERGES INTO ABERCORN EXTENSION.

TURN RIGHT ONTO MALL BLVD.

AT THE THIRD RED LIGHT, TURN LEFT ONTO WATERS AVE.

DRIVE APPROXIMATELY ONE QUARTER MILE.

PARK SOUTH OFFICE COMPLEX IS ON THE LEFT, DIRECTLY ACROSS FROM THE ENMARK GAS STATION. SUITE E-2 IS ON THE LEFT SIDE.

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DIRECTIONS TO DR. CYNTHIA TURNER'S ALTERNATE OFFICE
REGENCY EXECUTIVE PLAZA
315 COMMERCIAL DR., SUITE C-3
SAVANNAH, GA 31406

FROM INTERSTATE 16 AND LYNES PARKWAY (516), MERGE INTO DERENNE AVE.

TURN RIGHT ON ABERCORN EXTENSION.

DRIVE APPROXIMATELY 1.5 MILES.

TURN LEFT ON EISENHOWER BLVD

DRIVE APPROXIMATELY HALF A MILE AND TURN RIGHT ON HODGSON MEMORIAL DR.

DRIVE ONE QUARTER MILE AND TURN LEFT ON COMMERICAL DR

REGENCY EXECUTIVE PLAZA WILL BE ON THE RIGHT, DIRECTLY AFTER FOX AND WEEKS FUNERAL HOME.

FROM INTERSTATE 95, TAKE 204 TOWARDS SAVANNAH, WHICH MERGES INTO ABERCORN EXTENSION

TURN RIGHT ONTO MALL BLVD.

AT THE SECOND LIGHT, TURN LEFT ONTO HODGSON MEMORIAL BLVD.

DRIVE TO THE FIRST LIGHT AND TURN RIGHT ON COMMERCIAL DRIVE.

REGENCY EXECUTIVE PLAZA WILL BE ON THE RIGHT AFTER FOX AND WEEKS FUNERAL HOME.

THE OFFICE IS ON THE RIGHT SIDE OF THE COMPLEX, NEAR THE BACK. LOOK FOR LONNIE SCARBORO, MD, PSYCHIATRY POSTED ON THE DOOR. DR. TURNER IS NOT POSTED ON THE DOOR.

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PATIENT INFORMATION

Name of patient: _____
(First) (MI) (Last)

Address: _____

City: _____ State: _____ Zip code: _____

Telephone(s): _____ _____ _____
(Home) (Work) (Cell)

May we leave messages for you at home? Y or N Answering machine? Y or N

May we contact you at work? Y or N Voice mail? Y or N

Marital status: _____ Age: _____ DOB: _____

Did you complete high school, technical school or college? Please circle

List any degrees: _____ Total # of educational years: _____

SS# _____ Employer: _____

Occupation: _____ How long:_____

Primary care physician: _____

Telephone: _____ Fax: _____

Insurance co:_____ Subscriber ID # _____

Group #_____ Insurance telephone # _____

Policy holders name: _____Policy holder's DOB#:_____

Policy holders SS#: _____ Is a preauthorization required? Y or N

Are you currently receiving Medicare benefits or Medicare disability? Y or N

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Self-pay patients are responsible for payment of the total charges for the initial evaluation. We cannot guarantee payment by the insurance company. Patients offering health insurance as complete or partial payment of their fees may do so by assigning anticipated insurance payments to Dr. Cynthia Turner. However, your deductible, co-payment or co-insurance is due at the time of service. **Payment is expected at the time of your visit.**

I hereby assign all medical benefits to Cynthia J. Turner, Ph.D. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL THE CHARGES WHETHER OR NOT PAID BY THE SAID INSURANCE COMPANY. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT.

_____ _____

SIGNATURE OF PATIENT **DATE**

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Statement of Client Rights and Responsibilities

1. My goal is to always treat you competently, ethically, and respectfully.

2. You can stop seeing me without any obligation other than to pay for services you have received or appointments not cancelled 24 hours in advance.

3. Feel free to ask questions about my approach and methods or to decline any recommendations I make.

4. You can see your records.

5. Our discussions are confidential. This means that, except as noted below, I won't release information that identifies you to anyone without your written permission.

6. In certain situations, by law, I must reveal information about you to others **even without your permission:**

(a) In emergencies, including the risk that you may harm yourself or others, I'll share information necessary to keep you and others healthy and safe.

(b) I am obligated to release to a court of law any information specifically described by a court order.

(c) I will report to the Department of Family and Children Services any reasonable suspicion I have that a minor is being abused or neglected.

(d) I will release any information necessary to collect any outstanding bill for services rendered to you.

Please show your understanding of the above by signing below.

_____ _____
Signature of patient Date

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HIPPA CONSENT FORM

☐ YES I HAVE READ AND UNDERSTOOD THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT WHICH HAS BEEN PRESENTED TO ME.

☐ YES I WOULD LIKE A COPY OF THE HEALTH INSURANCE
☐ NO PORTABILITY AND ACCOUNTABILITY ACT.

SIGNATURE: _____

PRINT: _____

DATE: _____

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AUTHORIZATION FOR COMMUNICATION

I hereby authorize communication between **CYNTHIA J. TURNER, Ph.D., and**

Name: **Memorial Health Bariatrics including all Team Members**

Address or Agency: **4600 Waters Avenue, Savannah, GA 31406**

Phone or Fax #: **912-350-3438 or 912-350-9037**

As agreed below. Unless revocation is received, this consent will expire one year after the date indicated. I understand that I have the right to revoke this consent at any time.

Patient name: _____

Date of birth: _____

I. **RELEASE AND OBTAIN INFORMATION:** For the purpose of psychosocial evaluation and referral for treatment.

INFORMATION TO BE RELEASED: Psychosocial report, MMPI-2 or MBMD, clinical interview data, and other test materials.

Patient signature: _____ Date: _____

Printed name: _____

Witness signature: _____ Date: _____

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AUTHORIZATION FOR COMMUNICATION

I HEREBY AUTHORIZE **CYNTHIA J. TURNER, PH.D**. TO MAIL A COPY OF MY PSYCHOSOCIAL EVALUATION TO MY HOME ADDRESS.

Date:_____

Patient name (print)_____

SIGNATURE:_____

WITNESS:_____

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AUTHORIZATON FOR COMMUNICATION

I hereby authorize communication between CYNTHIA J. TURNER, Ph.D., and

Name: Anisa Grantham, LPC, NCAC_(Instructor for Success Habits Workshop)

Address or Agency: 613 Towne Park Drive West, Suite 103 Rincon, GA 31326_____

Phone #: 912-826-0918 Fax #: 912-826-0959

As agreed below. Unless revocation is received, this consent will expire one year after the date indicated. I understand that I have the right to revoke this consent at any time.

Patient Name: _____

Date of Birth: _____

I. RELEASE AND OBTAIN INFORMATION for the purpose of: Psychosocial evaluation and referral for treatment.

Information to be released: Psychosocial report, phone consultation, and other test materials.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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IMPORTANT INFORMATION

The physicians at Memorial Health Bariatrics offices require that ALL information, concerning previous and current mental health issues and prescribed medications, are included in the psychological evaluation when presented to the bariatric team, prior to clearance for bariatric weight loss surgery.

You can start the process prior to your appointment. The sooner this information is received, the sooner your evaluation will be presented to the bariatric team.

The following form is an authorization to obtain records from all of the physicians, psychiatrists, psychologists, and other doctors you have previously seen and are currently seeing, related to any mental health issues and pain management including prescribed medications.

Please print the following form for each doctor and complete the form with all of the requested information.

We look forward to working with you soon.

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HIPAA COMPLIANT AUTHORIZATION

Patient Requesting Release
Patient's Name _____ Date of Birth _____ SSN: _____

Full Address: _____ Phone: : _____

Provider Allowed to Release or Obtain Records:

Cynthia J. Turner, Ph.D.
7505 Waters Avenue, Suite E2
Savannah, Georgia 31406

Pursuant to HIPPAA Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. § 164.508 & 164.512, I hereby authorize you to use or disclose or obtain my protected health information, as described below. I further authorize the following individual or organizations to **release** or **obtain** such health information verbally or in writing:

Doctor's Name: _____ Address _____

City/State/Zip _____Phone#: _____ Fax#: _____

The purpose of the requested use or disclosure or obtaining is for Psychological Evaluation. The information to be used or disclosed or obtained includes the following specified information:

Mental health, psychotherapy notes and pertinent records, including information related to my identity, diagnosis, prognosis and/or treatment.

Federal and state laws protect the information disclosed pursuant to this Authorization. I understand that if the authorized recipient of the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed or re-obtained and no longer protected. Further, pursuant to O.C.G.A. § 24-9-47, state law prohibits a recipient from making any further disclosures of test results relating to HIV or AIDS without the specific written consent of the person to whom such information pertains.

I understand that my express consent is required to release or obtain any health care information relating to testing/diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS Virus, sexually transmitted diseases, psychiatric disorders/mental health, or drug and or alcohol use, you are specifically authorized to release or obtain all health care information relating to such diagnosis, testing or treatment.

I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release or obtain medical records for all dates including all diagnostic tests of any type and reports, history, hospitalization, diagnosis, prognosis, treatment, medication and pharmacy records, correspondence, consults, statement of charges or expenses.

This consent is subject to revocation at any time except to the extent the action has been taken thereon. This authorization and consent will expire in one year from the date of authorization written below. I understand that the Recipient of my health information may be charged for the service of releasing or obtaining medical information.

I understand that I have the right to revoke this Authorization at any time, and in order to do so, I must present a written revocation to Provider named above. I understand that the revocation will not apply to information that already has been released or obtained in response to or in reliance upon this Authorization, I understand that I need not sign this Authorization in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility benefits. I understand that I may receive a copy of this Authorization form, after signing it.

Signature of Patient If Applicable- Patient's Authorized Representative

_____(Date) _____ _____ (Date) _____

Relationship to Patient: _____

CLINICAL INTERVIEW & EVALUATION

Welcome! Thank you for taking the time to answer the following questions prior to our interview. This will give us more time to discuss issues and test results in-depth. I'm looking forward to speaking with you soon.

Date _____ Name_____ DOB _____ Age _____

Gender _____ Race_____ Surgery: Lap-band ____ Roux-en-Y ____ Sleeve _____

Surgeon: Oliver C. Whipple, MD_____ Robert J. Kelly, Jr., MD _____

Current height: _____ ft. _____ inch

Current BMI: _____ Current weight: _____ Highest weight/BMI: _____ Year _____

When did your problem with obesity begin? _____

Were there specific issues such as: stopping smoking, pregnancy, illness, divorce, stress, shift work, with a surge of weight gain? YES or NO If yes, please circle.

Were you adopted? _____ If so at what age? _____

Please list your biological mother / father / brothers/ sisters (half & full) and their ages. Indicate approximately their weight, and if they are living or deceased.

Mother's age _____ Wt._____ Living/Deceased/ Cause of death _____

Father's age _____ Wt._____ Living/Deceased/ Cause of death _____

How many brothers do you have? _____ How many sisters do you have? _____

CIRCLE BROTHER OR SISTER:

Brother's/Sister's Age ___Wt. ____ Living/Deceased/Cause of death _____

Brother's/Sister's Age ___Wt. ____ Living/Deceased/Cause of death _____

Brother's/Sister's Age ___Wt. ____ Living/Deceased/Cause of death _____

Brother's/Sister's Age ___Wt. ____ Living/Deceased/Cause of death _____

Brother's/Sister's Age ___Wt. ____ Living/Deceased/Cause of death _____

Brother's/Sister's Age ___Wt. ____ Living/Deceased/Cause of death _____

Brother's/Sister's Age ___Wt. ____ Living/Deceased/Cause of death _____

Brother's/Sister's Age ___Wt. ____ Living/Deceased/Cause of death _____

Brother's/Sister's Age ___Wt. ____ Living/Deceased/Cause of death _____

Do you have extended family members with morbid obesity issues such as grandmother, grandfather, aunts, uncles, cousins on either side? **(CIRCLE ANSWERS)**

CIRCLE ANY OF THE FOLLOWING MEDICAL CONDITIONS YOU HAVE NOW OR HAVE HAD IN THE PAST:

Heart attack	Dependent on pain medication
High blood pressure	Back pain
Congestive heart failure	Constant fatigue
Stroke	Bladder incontinence
Clots	Polycystic ovarian syndrome
Snoring	Asthma
Sleep apnea	Gallstones
Swelling/edema	Infertility
Fatty liver disease	Endocrine/metabolism
Diabetes/any stage	Depression
Elevated cholesterol/triglycerides	Anxiety
GERD	Pseudotumor
Osteoarthritis	Quality of life issues
Joint pain	Cancer /chemotherapy
Gout	Shunt

List other significant medical problems not listed above: _____

Are you currently up-to-date with routine visits with your physician including: colonoscopy, mammograms, physicals, pap smears, and blood work? Y / N

Do you take medications as directed? Y / N

List all major surgeries, including Lap-Band or Roux-en-Y gastric bypass, liposuction or Other weight loss surgeries: _____

_____

Morbid obesity has many causes, including genetics, medical issues, your schedule and access to different foods. Eating patterns and food choices are part of the equation. Please describe in general what you think your biggest problem is with food and eating behaviors and in your opinion, what has caused your obesity? _____

_____

How many major diets have you tried? Please list them: _____

_____

What was the most weight you lost, on which diet, what year, and how long did you maintain the weight loss?

Most weight lost _____ Diet _____

Year _____ How long _____

Do you know others who have had weight loss surgery? Y / N

CIRCLE ANY BEHAVIORS YOU HAVE HAD *** IN THE PAST FIVE YEARS ***** AND INDICATE THE FREQUENCY IN TIMES PER WEEK WHICH THEY MAY OCCUR.**

Addiction to any specific food Y / N Times per week _____

List foods: _____

Bingeing (extreme eating) unusually large amounts of food in a short time span, such as 2-3 hours, and feeling out of control)
Y / N Times per week _____

Buffets Y / N Times per week _____

Fast food restaurants Y / N Times per week _____

Sweetened beverages Y / N Times per week _____

Sodas, tea, coffee or _____ Totals_____

Craving specific foods Y / N Times per week _____

List foods: _____

Grazing Y / N Times per week _____

Snacking Y / N Times per week _____

Picking or tasting Y / N Times per week _____

Night eating Y / N Times per week _____

Skipping meals Y / N Times per week _____

Hiding foods Y / N Times per week _____

Eating secretly Y / N Times per week _____

Eating when driving Y / N Times per week _____

Do experience a fullness sensation after eating? Y / N

Eating when upset, sad, anxious bored, angry, emotional, when driving, stressed, watching TV? **(CIRCLE ANSWERS)** Y / N Times per week _____

Purging (vomiting or laxatives) Y / N Times per week _____

Unusually large intake amounts of: fats, carbohydrates, or sweets. Number per week ___ (**CIRCLE ANSWERS)**

If no then, do you eat less than, about same, more than, or much more than an average person? **(CIRCLE ANSWERS)**

What was your estimated daily calorie intake before making changes to your diet? _____

Have you ever been diagnosed with anorexia, bulimia, binge eating disorder, exercise bulimia, sugar addiction, or purging/laxatives? Y / N

Please list: _____

What is your goal weight or desired weight? _____

What are your goals, expectations, and hopes for yourself following your weight loss?

_____

_____

PERSONAL, SOCIAL AND FAMILY HISTORY:

Where did you grow up? City _____ State _____

Did you grow up in a family with one or both parents, single, or married? **(Circle)**

Biological parent's occupations: Father's _____

Mother's _____

Step-parent (s) occupations: Father's _____

Mother's _____

Who raised you? _____

Describe any divorce or step-parenting experiences you may have had as a child:

_____

_____

Describe your most painful childhood memories: _____

_____

_____

Describe what role food played in your home growing up: _____

_____

Was there alcohol abuse, substance abuse or family violence in your home during your childhood? **If yes, please circle your answers.**

Have you ever been a victim of physical abuse, sexual abuse, verbal abuse, neglect, poverty, assault, victim of a violent crime? **If yes, please circle your answers.**

Explain:_____

Have you served in the military, been deployed or worked in a war zone as a civilian? (Continue on back if necessary)
If yes, please explain: _____

Have you ever been diagnosed with PTSD (post-traumatic stress disorder)? Y / N

If so, when _____Who made the diagnosis: _____
Were you prescribed medication? If so, please list: _____

Number of marriages you have had and how long: _____

_____

Number of divorces and issues related to divorce: _____

_____

Current marriage/spouse's age _____ spouse's occupation _____

Spouse's weight issues: _____

Does your spouse support your efforts to lose weight? Y / N

Does your spouse tease you about your weight, make painful remarks, or try to control it? Y /N

Does your spouse encourage you to eat food which leads to weight gain? Y /N

Is your spouse abusive in any way past or present? Y/N

Explain: _____

Describe your greatest marital challenge: _____

_____

Do you have children? **If yes, please complete, circle male or female:**

Male / Female Age: _____ Weight: _____ General Health _____

Male / Female Age: _____ Weight: _____ General Health _____

Male / Female Age: _____ Weight: _____ General Health _____

Male / Female Age: _____ Weight: _____ General Health _____

Please describe your current home environment: _____

_____

Do you currently own your home, rent, live with parents or roommate? (**CIRCLE**)

List others who live in your home and if so is the environment safe and supportive:

_____

_____

List family members who have any of the following and circle issue:

Psychiatric disorders, bipolar disorder, hallucinations, schizophrenia, depression, anxiety, institutionalization, psychiatric hospitalization or other:

_____

Substance abuse/alcoholism: _____

Suicides/homicides: _____

NSSI: non-suicidal self-injury/including cutting, hair pulling, skin picking, burning skin, head banging, punching self, scratching, drawing blood.

_____

_____

Describe any structured exercise program last year: _____

_____

CIRCLE any that apply: **recent legal problems / lawsuits / bankruptcy / major financial problems / DUI/ loss of employment/homeless/ food shortages**

Describe your stress management strategies, including hobbies, recreational activities, leisure activities, drinking alcohol, using marijuana: _____

_____

CIRCLE any that apply: Outpatient psychotherapy, inpatient psychiatric hospitalization, consult with a psychiatrist, intensive pastoral counseling, marital counseling, drug or alcohol rehab. Past or current, in childhood or as an adult. Management of mood issues through your primary care physician.

Describe: _____

_____

List any psychoactive medications you have ever used or are currently using, including antidepressants, anxiety meds, mood stabilizers, pain pills, meds for ADD or ADHD, sleeping pills or other:

_____

Have you ever abused or been addicted to alcohol, drugs, gambling, spending, shopping, or sex? **If yes, please circle.**

YOU ARE REQUIRED TO BRING A LIST OF ALL MEDICATIONS CURRENTLY BEING TAKEN. INCLUDING FREQUENCY AND DOSAGE AMOUNTS.

LIST BELOW:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

On a scale of 0 - 10, **(10 being the highest)** how would you rate your stress level:

_____

On a scale of 0 - 10, **(10 being the highest)** how would you rate your level of coping and functioning, in daily responsibilities, activities, and work performance:

_____

Describe your current moods, day to day: _____

CIRCLE AND EXPLAIN if you have or have had any of the following symptoms:

GENERALIZED ANXIETY

ANXIETY/PANIC ATTACKS

AGORAPHOBIA (unable to leave your home due to anxiety)

SOCIAL ANXIETY

OBSESSIVE COMPULSIVE DISORDER

PHOBIAS/SPECIFIC OR NONSPECIFIC

PTSD (nightmares, flashbacks, or vivid recalls)

RECURRENT OR SEVERE INSOMNIA/NIGHTMARES

SLEEP APNEA/SNORING

DEPRESSION

HOPELESSNESS

IRRITABILITY

CHRONIC STRESS

FRUSTRATION

WITHDRAWAL OR ISOLATION

VOMITING AFTER EATING LARGE AMOUNTS OF FOOD

ANGER MANAGEMENT PROBLEMS

EATING SECRETLY

BOTTLING ANGER

HOLDING MY FEELINGS IN

PEOPLE-PLEASING

EXPLOSIVE EPISODES

BIPOLAR DISORDER

MANIC EPISODE

BORDERLINE PERSONALITY DISORDER

BODY DYSMORPHIC DISORDER **(severe anxiety around a feature of the body)**

DISABILITY OF ANY KIND **(explain)**

IMPAIRED ACTIVITIES OF DAILY LIVING **(explain)**

PSYCHOSIS - HALLUCINATIONS/ HEARING VOICES/SEEING THINGS

MENTAL OR PSYCHIATRIC BREAKDOWN

SELF-INJURIOUS BEHAVIOR **(cutting, burning, drinks harmful liquids)**

SUICIDE ATTEMPT / OVERDOSE **(explain)**

THOUGHTS OF SUICIDE **(past or present)**

ELECTRO CONVULSIVE SHOCK THERAPY; TMS; KETAMINE

ATTENTION DEFICIT DISORDER/ ADHD MEDS

SEXUAL PROBLEMS

ROAD RAGE

RECKLESS DRIVING

EXTREME MOOD SWINGS

SKIN PICKING

HAIR PULLING

HYPOMANIA/"FEELING HIGH"

Check any of the following statements that apply to you:

_____ Thoughts of food occupy much of my time.

_____ Sometimes I eat huge amounts of food, feel sick and out of control.

_____ I have sometimes purged myself by inducing vomiting or using a laxative or enema after overeating.

_____ I overeat by snacking or grazing continuously during the day.

_____ I hide food for future bingeing or eating.

_____ I consider food to be my best friend.

_____ I use food frequently to manage emotions, stress, or boredom.

_____ I have specific ways to eat when I am emotionally upset, sad, angry, afraid, anxious, or ashamed.

_____ I prefer to eat alone or I am uncomfortable eating with others.

_____ Sometimes when eating, I am afraid I will lose control and not be able to stop.

_____ I frequently eat large amounts of high calorie, sugary foods.

_____ I frequently eat desserts, candies, pastries or other sweets.

_____ I feel addicted to: fruit juices/chocolate/candy/ice cream/cokes or sodas. **(CIRCLE)**

_____ I feel addicted to **_____(fill in the food).**

_____ Following ingestion of a very large amount of food, I feel "hung over," bloated, or fatigued the next day.

_____ I feel depressed and guilty after eating a large amount of food.

_____ In the past, I have been told that I have an eating disorder such as binge eating disorder, anorexia, bulimia, exercise bulimia, night eating syndrome.

_____ I drink very large amounts of sugar sweetened beverages such as regular Cokes, Starbucks, Kool-Aid, fruit juices, or sweet tea. **(CIRCLE)**

Explain:_____

_____ I am a big stress eater.