**Adult LCOH ED Program Intake Form**

Date:\_\_\_\_\_/\_\_\_\_\_/2010 DOB: \_\_\_\_\_/\_\_\_\_\_/19\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nickname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person completing this section (if different than patient):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient:

(1)Family Member (2)Physician (3)Other, please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please answer the following questions to the best of your ability**

1. What problems are you having which prompted you to come to the Lindner Center of HOPE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What are your goals/expectations for treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eating Disorder History

**These questions are designed to help you obtain the best possible treatment specific to your needs. Please answer each question completely. Use the back of the page to complete your responses if needed.**

**Food Intake:**

1. Do you have any “rules” or food patterns which limit your food intake? (0)No (1)Yes

**If yes, please explain**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What is your estimated number of calories eaten daily?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Is there significant variability in the number of calories you eat daily? (0)No (1)Yes

**If yes, please explain**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe a typical day of eating (if you do not have a typical day, please list what you ate yesterday):

1. Describe what you would eat for a typical *breakfast*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What time do you typically eat breakfast? \_\_\_\_:\_\_\_\_ am/pm
3. Describe what you would eat for a typical *morning snack*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   1. Around what time do you typically eat that? \_\_\_\_:\_\_\_\_ am/pm
4. Describe what you would eat for a typical *lunch*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   1. Around what time do you typically eat that? \_\_\_\_:\_\_\_\_ am/pm
5. Describe what you would eat for a typical *afternoon snack*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   1. Around what time do you typically eat that? \_\_\_\_:\_\_\_\_ am/pm
6. Describe what you would eat for a typical *dinner*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   1. Around what time do you typically eat that? \_\_\_\_:\_\_\_\_ am/pm
7. Describe what you would eat for a typical *evening snack(s)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   1. Around what time do you typically eat that? \_\_\_\_:\_\_\_\_ am/pm
8. Do you restrict fluids? (0)No (1)Yes

**If yes, please explain**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you eat food in a way that feels out of control and/or associated with a feeling of disconnected to physical hunger? (0)No (1)Yes

**If yes, please explain**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Binge Eating** (refers to a pattern of eating large amounts of food rapidly in a brief time period)

1. Describe what happens during a typical binge (where are you, who are you with, what are you feeling, and what do you eat during a typical binge): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Number of days you binged in the past month: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Average number of times per day you binged in the past month: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Approximate age when you first binged: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Compulsive Eating** (refers to eating large amounts of food over an extended period (i.e. throughout the day) instead of all at once)

1. Number of days you ate compulsively in the past month: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Approximate age when you first ate compulsively: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. What do you eat during a typical episode in which you eat compulsively? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purging Behaviors**

1. Do you compensate for eating by using any of the following:
   1. Laxatives: (0)No (1)Yes If yes, quantity:\_\_\_\_\_ and frequency of use:\_\_\_\_\_day/wk
   2. Diuretics: (0)No (1)Yes If yes, quantity:\_\_\_\_\_ and frequency of use:\_\_\_\_\_day/wk
   3. Fat absorbers: (0)No (1)Yes If yes, quantity:\_\_\_\_\_ and frequency of use:\_\_\_\_\_day/wk
2. Do you compensate for eating by vomiting? (0)No (1)Yes

**If so, how many times each day is this occurring**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you utilize diet pills or other medications (prescribed or over the counter) in an effort to suppress your appetite? (0)No (1)Yes

**If so, which one(s) and how often**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Approximate age when you began purging behaviors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Please provide any additional information you believe is important: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Exercise**

1. Are you involved in any sports or exercise? (0)No (1)Yes
2. What motivates you to participate in sports or exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How many hours per day have you exercised over the past month? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Approximately how many days have you exercised over the past month? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Do you become irritable and/or anxious if you are not able to engage in your exercise routine?

(0)No (1)Yes

1. Was there a time when you exercised more or less? (0)No (1)Yes

**If so, how much did you exercise**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you exercise against the advice of a health care provider, or despite illness or pain?

(0)No (1)Yes

**Weight History**

1. Do you weigh yourself routinely? (0)No (1)Yes

**If so, describe frequency**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Age:\_\_\_\_\_\_\_ and weight:\_\_\_\_\_\_\_\_\_\_ at the onset of eating disorder symptoms.
2. Highest lifetime weight:\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **EDO Staff Only** |  |  |
| Current Height:\_\_\_\_\_\_\_\_\_\_\_\_ | Current Weight:\_\_\_\_\_\_\_\_\_\_\_\_ | BMI:\_\_\_\_\_\_\_ [*Calculate*] |
| SittingBP:\_\_\_\_\_\_\_\_ Pulse:\_\_\_\_\_\_ | StandingBP:\_\_\_\_\_\_\_\_ Pulse:\_\_\_\_\_\_ | Lab work/ECG (0)Yes (1)No |

1. Lowest weight at current height:\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Describe any weight fluctuations over the course of your life: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General ED Information**

1. When did your eating disorder behavior first start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What behavior? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. List any health problems you have that may have been caused by your eating disorder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For women:

1. Age of onset of first period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. When was your last period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Are your periods irregular? (0)No (1)Yes

**If so, describe**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. In the past two years, have you missed three or more periods? (0)No (1)Yes
2. Have you ever been pregnant? (0)No (1)Yes

**If so, what was the outcome?\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past psychiatric treatment:**

Prior treatment experiences (list providers, places, dates and how it impacted you):

1. Outpatient psychotherapy: (0)No (1)Yes

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Outpatient psychiatry/medication management: (0)No (1)Yes

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Intensive outpatient treatment: (0)No (1)Yes

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Day treatment/partial hospitalization: (0)No (1)Yes

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Residential treatment: (0)No (1)Yes

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Inpatient psychiatric hospitalization: (0)No (1)Yes

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Inpatient medical hospitalization: (0)No (1)Yes

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever been diagnosed with and/or have experienced any of the following conditions that sometimes accompany eating disorders:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Depression |  |  | Suicide attempt |
|  | Bipolar disorder/mania/hypomania/extreme mood fluctuation |  |  | Other impulsivity concerns (e.g., shopping, sexual inmpulsivity) |
|  | Premenstrual symptoms |  |  | Self-harming behavior |
|  | Postmenopausal symptoms |  |  | Substance abuse |
|  | Attention deficit disorder |  |  | Alcohol abuse |
|  | Panic disorder |  |  | Hoarding of food |
|  | Social phobia |  |  | Shoplifting or stealing |
|  | Anxiety disorders |  |  | Anxiety or inability to shop for food and/or clothing |
|  | Obsessive compulsive |  |  | Anxiety or inability to eat in restaurants or take out foods |

1. Which psychiatric medications have you taken in the past and what were the benefits and/or side effects you had from them? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you taking any psychiatric medications now? (0)No (1)Yes

**If yes, please check all the current medications:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Depakote |  | Ambien |
|  | Lamictal |  | Lunesta |
|  | Lithium |  | Rozeram |
|  | Neurontin |  | Sonata |
|  | Trileptal |  | Somnote (chloral hydrate) |
|  | Topamax |  | Trazodone |
|  | Tegretol |  |  |
|  | Abilify |  | Ativan |
|  | Geodon |  | Klonopin |
|  | Risperdal |  | Xanax |
|  | Seroquel |  | Valium |
|  | Zyprexa |  | Zyprexa Zydis |
|  | Campral |  | Antabuse |
|  | Celexa |  | Adderall |
|  | Effexor |  | Adderall XR |
|  | Lexapro |  | Concerta |
|  | Paxil |  | Focalin |
|  | Prozac |  | Focalin XR |
|  | Wellbutrin XL |  | Metadate |
|  | Zoloft |  | Metadate CD |
|  | Cymbalta |  | Ritalin |
|  | Remeron |  | Strattera |
|  | Luvox |  | Provigil |
|  | Dexedrine |  |  |
| Other: | |  |  |
| Prescribing Physician: | |  |  |

1. Please review the following and check any current symptoms that pertain to you:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Depressed Mood |  | Inflated self-esteem |
|  | Stopped enjoying usual activities |  | Don’t seem to need sleep |
|  | Lost or Gained weight without meaning to |  | Excessive talking |
|  | Sleep too much or not enough |  | Racing thoughts |
|  | Agitated or sluggish |  | Highly distractible |
|  | No energy/always tired |  | Try to do way too much |
|  | Feel guilty/worthless |  | Impulsive behavior |
|  | Can’t think or concentrate |  | See or hear things that may not be real |
|  | Thoughts of death or suicide |  | Suspect or believe things that may not be real |
|  | Often tense/unable to relax |  | *Life Problems that Currently affect you:* |
|  | Excessive worry |  | Problems/losses within my family |
|  | Panic Attacks |  | Problems/losses among my friends/community |
|  | Afraid/unable to leave home |  | Educational problems |
|  | Extreme unreasonable fears |  | Occupational problems |
|  | Intense fear of social situations |  | Housing problems |
|  | Can’t prevent repetitive thoughts |  | Financial/economic problems |
|  | Can’t prevent repetitive behaviors |  | Can’t get adequate health care |
|  | Intrusive, upsetting memories of past event |  | Problems with the law, legal system |
|  | Always on guard/never feel safe |  |  |
|  | Body overreacts to “stress” |  |  |
|  | Destructive/violent thoughts or behaviors |  | Discipline problems at work |
|  | Attempts to hurt, harm, or mutilate self |  | Careless, high-risk behavior |
|  | Anger outbursts |  |  |

**General Medical History**

1. Do you have a Primary Care Physician? (0)No (1)Yes

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Date of Last Physical Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Date of Last Laboratory Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Do you suffer from any of the following general medical problems?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Chest Pain |  | Cancer |
|  | Heart Attack |  | Lung Disease |
|  | Coronary Artery Disease |  | Asthma |
|  | Rheumatic Fever |  | Emphysema |
|  | High/Low Blood Pressure |  | Chronic Cough |
|  | Stroke |  | Bronchitis |
|  | Heart Palpations |  | Pneumonia |
|  | Heart Surgery |  | Tuberculosis |
|  | Pace Maker Implant |  | Shortness of breath |
|  | Neurological Disorders |  | Arthritis |
|  | Seizures |  | Muscle Cramps |
|  | Epilepsy |  | Muscle Stiffness |
|  | Fainting |  | Weakness |
|  | Vertigo/Dizziness |  | Tremors |
|  | Motor Difficulties |  | Numbness |
|  | Serious Head Injury |  | Difficulty Walking |
|  | Recurring Headaches |  | Uncontrolled Movements |
|  | Kidney Disease |  | Liver Disease |
|  | Diabetes |  | Jaundice |
|  | Thyroid Disease |  | Hepatitis |
|  | Hormone Problems |  | Stomach Ulcers |
|  | Fever or Sweats |  | Nausea/Vomiting |
|  | Blood Disease |  | Unusual Diet |
|  | Anemia |  | Abdominal Pain |
|  | Bruise Easily |  | Skin Rash |
|  | Nose Bleed |  | Skin Ulcer/Lesion |
|  | Sexually Transmitted Disease |  | Glaucoma |
|  | HIV |  | Visual Spots |
|  | Sexual Difficulties |  | Double Vision |
|  | Gynecological Problems |  | Hearing Problems |
|  | Prostate Problems |  | Speaking Problems |
|  | Memory Problems |  | Sinus or Nasal Problems |
|  | Early Fatigue |  | Recurrent Infection of any kind |
|  | Daytime Sleepiness |  | Depressed Immune System |
|  | Difficulty Sleeping |  | Recent Trauma |
|  | Concentration Problems |  | Other |

1. Do you take any prescription medications for your general medical problems? (0)No (1)Yes

**If so, please list:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you take over the counter medications or herbal supplements? (0)No (1)Yes

**If so, please list:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you allergic to any medications? (0)No (1)Yes

**If so, please list medications and allergic reactions:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you undergone any surgical procedures? (0)No (1)Yes

**If so, list the surgical procedure with the date(s) of surgery:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Do you have problems with chronic physical pain? (0)No (1)Yes
2. Rate average pain level (Circle one): 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (worst)
3. Have you ever suffered a severe head injury with loss of consciousness or concussion?

(0)No (1)Yes

**If so, please describe:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever had a seizure? (0)No (1)Yes

**Alcohol, Drug and Tobacco Use** Check if none

1. **Alcohol:**
   1. Current use:\_\_\_\_\_\_\_\_\_\_\_\_ Date of last use:\_\_\_\_/\_\_\_\_/\_\_\_\_ Past use:\_\_\_\_\_\_\_\_\_\_\_\_
2. Problems related to use (Legal, Financial, Health, Relationship)? (0)No (1)Yes

**If so, please list:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Was treatment required? (0)No (1)Yes

**If so, please describe:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Illicit drug and/or prescription drug abuse:

|  |  |  |  |
| --- | --- | --- | --- |
| Substance | Date of Last Use | Problems related to use | Treatment Required |
| Benzodiazepines  (Valium, Xanax, Ativan) |  | (0)No (1)Yes | (0)No (1)Yes |
| Caffeine |  | (0)No (1)Yes | (0)No (1)Yes |
| Marijuana |  | (0)No (1)Yes | (0)No (1)Yes |
| Cocaine |  | (0)No (1)Yes | (0)No (1)Yes |
| Designer Drugs  (Club, Drugs: G, X) |  | (0)No (1)Yes | (0)No (1)Yes |
| Hallucinogens  (LSD, Mushrooms) |  | (0)No (1)Yes | (0)No (1)Yes |
| Inhalants  (Gasoline,Glue, Aerosol) |  | (0)No (1)Yes | (0)No (1)Yes |
| Methamphetamines  (Speed, Ice, Ritalin) |  | (0)No (1)Yes | (0)No (1)Yes |
| Opiates/Methadone  (Vicodin, Oxycontin, Heroin) |  | (0)No (1)Yes | (0)No (1)Yes |
| Other |  | (0)No (1)Yes | (0)No (1)Yes |

1. Tobacco Use: (0)No (1)Yes Amount per day:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

1. Where were you born? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Where did you grow up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Did your parents stay together while you were growing up? (0)No (1)Yes

**If no**, how old were you when they separated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Father’s occupation while you were growing up: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Mother’s occupation while you were growing up: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. How many siblings do you have?  None \_\_\_\_\_ Brothers \_\_\_\_\_ Sisters
4. Were there any complications at your birth (premature birth, major medical problems)? (0)No (1)Yes

**If so, please describe:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Any problems in your early development (learning to walk, talk, etc)? (0)No (1)Yes

**If so, please describe:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Did you suffer from any major illnesses/injuries while you were growing up? (0)No (1)Yes

**If so, please describe:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you/were you a victim of any form of physical/sexual/emotional abuse?

|  |  |  |  |
| --- | --- | --- | --- |
| Physical Abuse | (0)No (1)Yes | Age of occurrence: | \_\_\_\_\_\_\_ |
| Sexual Abuse | (0)No (1)Yes | Age of occurrence: | \_\_\_\_\_\_\_ |
| Emotional Abuse | (0)No (1)Yes | Age of occurrence: | \_\_\_\_\_\_\_ |

1. What is your highest level of education? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Are you currently employed? (0)No (1)Yes

**If yes, where?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you currently involved in a romantic relationship? (0)No (1)Yes

**Spouse’s/partner’s first name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How long have you been together?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How would you describe your relationship?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What is your spouse’s/partner’s occupation?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Have you been involved in any previous significant intimate/romantic relationships?

(0)No (1)Yes

**If so, please describe:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have any children? (0)No (1)Yes

**Names & Ages**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What are some things you enjoy doing (hobbies, sports, past times)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever been convicted of any crimes, incarcerated in prison, or placed on probation?

(0)No (1)Yes

**If so, please describe:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you belong to a particular religion or spiritual group? (0)No (1)Yes

**If so, what is your level of involvement: \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

1. Is there any history of obesity, eating disorder, other mental illness or substance abuse among your blood relatives?

(0)No (1)Yes

**If yes, please describe below:**

|  |  |  |
| --- | --- | --- |
| **Fathers Side:** | **Mothers Side:** | **Siblings:** |
|  |  |  |

**Social Supports**

1. Is there anyone you trust or confide in during times of trouble? (0)No (1)Yes

**Name Supports**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have any religious ties or involvement in a church? (0)No (1)Yes

**If so, please describe:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Living Situation**

1. Do you live in a  House  Apartment  Manufactured Home  Other

Own or  Rent

1. Do you live alone? (0)No (1)Yes

**If not, who else lives with you?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have plans to move in the near future? (0)No (1)Yes

**If so, where**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have any pets? (0)No (1)Yes

**List**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_