



AC4W Pediatrician Intake Form
www.atlantacenterforwellness.com
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Patient Name: _____ Age _____ DOB _____

Gender (at birth & identified) & preferred pronouns (he/she/they): _____

Pt. cell phone: _____ Email: _____

Parent(s) Names: _____

Marital Status _____

If pt. is a minor and parents are divorced, who has custody/decision-making rights? _____

Parent(s) Occupation(s): _____

Return phone number mother: _____ father: _____

Email mother: _____ Email father: _____

Who are all the people living with your child (age and relationship to child)? _____

Child's School: _____ Current Grade _____

Learning Concerns: _____



What are the current struggles at home regarding eating behaviors/feeding/meal compliance?

Psychiatric/ Behavioral Concerns: _____

Pattern/start of Eating Concerns:



Current Eating Disorder symptom use (circle each one that applies) and how often (per day/week) (if unknown, please indicate that):

Restrictive Eating _____

Binge _____ Purge (vomit) _____

Diet pills _____ Laxatives _____

Diuretics _____ Excessive Exercise _____

Any other relevant symptoms _____

Last menstrual period (if applicable): _____

Current height _____ Weight _____

Highest and lowest weight (with approximate dates): _____

Psychiatrist _____

Therapist _____

Dietician _____

Pediatrician _____ Practice: _____

Phone number: _____ Email if known: _____

Significant Medical History _____



Medical or Psychiatric Hospitalizations (including name of Res/PHP/IOP) with dates:

Current Medications and prescribing doctor: _____

Allergies: _____

Pertinent Family Medical/Psychiatric History:

Printed name and signature of the person filling out this form and relationship to primary patient:

Printed Name: _____ Relationship: _____

Signature _____ Date: _____

Who referred you to AC4W and/or Dr. Hopkins? _____

***Please attach or send growth chart, most recent labs and vital signs, and consent to speak with treatment team, including pediatrician. Send to DrHopkinsAC4W@gmail.com