



**Taylor Trussell, LPC**  
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**Eating Disorder Intake Form**

How did you hear about Taylor/ AC4W \_\_\_\_\_

Client's Name \_\_\_\_\_

Cell phone number: \_\_\_\_\_

Email: \_\_\_\_\_

Gender (he/she/they): \_\_\_\_\_

Who lives at home with client? \_\_\_\_\_

Occupation or school and grade: \_\_\_\_\_

Learning Concerns: \_\_\_\_\_

If Client is a Minor, Parent(s) Name(s), phone number(s) and email(s):

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

Marital Status \_\_\_\_\_

If Divorced, who has custody/decision-making rights? \_\_\_\_\_

Parent(s) Occupation(s): \_\_\_\_\_

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

\_\_\_\_\_



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Psychiatric/ Behavioral Concerns:

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Pattern/start of Eating Concerns:

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Current Symptom use and how often: Restrictive Eating \_\_\_\_\_ Binge \_\_\_\_\_

Purge \_\_\_\_\_ Diet pills \_\_\_\_\_ Laxatives \_\_\_\_\_ Diuretics \_\_\_\_\_

Excessive Exercise \_\_\_\_\_ Sensory Issues \_\_\_\_\_

Any other relevant symptoms \_\_\_\_\_

Last menstrual period (if applicable): \_\_\_\_\_

Current height \_\_\_\_\_ Weight \_\_\_\_\_

Highest and lowest weight (with dates): \_\_\_\_\_



Psychiatrist \_\_\_\_\_

Therapist \_\_\_\_\_

Dietician \_\_\_\_\_

Pediatrician \_\_\_\_\_

Medical History \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Pertinent Family Medical/Psychiatric History:

\_\_\_\_\_

\_\_\_\_\_

\*\*\*Please attach or send growth chart, most recent labs and vital signs if you have them and consent to speak with treatment team including pediatrician. Thank you!!