



Jenny Romano, LPC, NCC Eating Disorder Intake Form

How did you hear about Jenny/ 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?



Psychiatric/ Behavioral Concerns:

Pattern/start of Eating Concerns:

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!!