Eating Disorder Intake Form

How did you hear about clinician/AC4W_____

Client's Name _____

Cell phone number: _____

Email: _____

Gender (he/she/them): _____

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!!