MELISSA PRESTON
COUNSELING

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CLIENT INFORMATION FORM

TODAY'S DATE:

NAME _____ AGE _____ DOB _____

NAME YOU WOULD LIKE ME TO CALL YOU _____

PHONE (HM) _____ (WK) _____ (CELL) _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMAIL _____ May I email you?_____
PLEASE NOTE: *email correspondence is not considered a confidential medium of communication*

MARITAL STATUS _____ Who do you live with? _____

Highest level of education? _____

EMPLOYER:

OCCUPATION:

HOURS/WEEK:

What issue(s) have caused you to seek counseling at this time?

What goals do you have for mental health and nutrition counseling?

Are you currently in any support groups or fellowships? (which ones?)

Do you have any medical problems:
(Diabetes, heart disease, hypertension, gastrointestinal disorders, etc)?

Please list any current medications (including over-the-counter):

Please list all vitamin, mineral, herbal or other dietary supplements:

Name of any physicians you are working with:
Phone Number:

Are you following a special diet at this time?
If yes, please indicate:

Current height:
Current weight:

Highest adult weight: Age:

Lowest adult weight: Age:

How do you presently think of yourself?

- ☐ Underweight
- ☐ At your normal weight
- ☐ Moderately overweight
- ☐ Very overweight

Do you have an eating disorder/disordered eating?
If yes, please describe:

DO YOU:

- ☐ Diet/yo-yo dieting **HOW OFTEN?**
- ☐ Binge **HOW OFTEN?**
- ☐ Vomit **HOW OFTEN?**
- ☐ Fast/restrict **HOW OFTEN?**
- ☐ Avoid foods **HOW OFTEN? WHAT FOODS?**
- ☐ Chew/Spit **HOW OFTEN?**
- ☐ Use laxatives **HOW OFTEN?**
- ☐ Use diuretics **HOW OFTEN?**
- ☐ Use Ipecac **HOW OFTEN?**
- ☐ Use enemas **HOW OFTEN?**
- ☐ Use diet pills **HOW OFTEN?**
- ☐ Abuse insulin **HOW OFTEN?**
- ☐ Exercise **HOW OFTEN?**
- ☐ Smoke **HOW OFTEN?**
- ☐ Drink alcohol **HOW OFTEN?**
- ☐ Use recreational drugs **HOW OFTEN?**
- ☐ Weigh yourself **HOW OFTEN?**

Are you preoccupied by numbers? (weight, clothing size, calories, etc.)

How many hours per day do you find yourself thinking about food?

Who does the grocery shopping?
Cooking?

How often do you eat out each week?

Are you a vegetarian?

Do you have any food allergies?

Do you follow Religious food restrictions?

The following 4 questions are ***for females only***:

1. Do you have irregular periods? ____ Yes ____ No
   If yes, please describe:

2. Are you currently taking oral contraceptives or any other hormone?____ Yes ____ No
   If yes, please list:

3. Are you pregnant? ____Yes ____ No
   If yes: How many weeks?
   Due date:

4. Are you lactating? ____ Yes _____ No
   If yes: How many weeks?

FAMILY-OF-ORIGIN HISTORY

RELATIVE	NAME	CURRENT AGE *or age at death & year*	HEALTH CONCERNS *or cause of death*	RELATIONSHIP STATUS
MOTHER				☐ Satisfactory ☐ Source of mild stress ☐ Source of major stress
FATHER				☐ Satisfactory ☐ Source of mild stress ☐ Source of major stress
SIBLING				☐ Satisfactory ☐ Source of mild stress ☐ Source of major stress
SIBLING				☐ Satisfactory ☐ Source of mild stress ☐ Source of major stress
SIBLING				☐ Satisfactory ☐ Source of mild stress ☐ Source of major stress
OTHER RELATIVE				☐ Satisfactory ☐ Source of mild stress ☐ Source of major stress
OTHER RELATIVE				☐ Satisfactory ☐ Source of mild stress ☐ Source of major stress

PHYSICAL & PSYCHOLOGICAL COMPLICATIONS

Please check all that apply

PHYSICAL

- ☐ changes to your hair, skin or nails
- ☐ menstrual irregularities
- ☐ fatigue, lethargy
- ☐ headaches
- ☐ osteoporosis
- ☐ electrolyte imbalance
- ☐ tingling/numbness
- ☐ heart irregularities
- ☐ delayed stomach emptying
- ☐ bloating, gas, and stomach pain
- ☐ blood in vomit
- ☐ reflux
- ☐ swollen salivary glands
- ☐ kidney complications
- ☐ dental problems
- ☐ dehydration
- ☐ constipation
- ☐ diarrhea
- ☐ edema (fluid retention)
- ☐ muscle cramps
- ☐ frequent injuries
- ☐ other: _____

PSYCHOLOGICAL

- ☐ depression
- ☐ suicidal thoughts
- ☐ social anxiety
- ☐ worrying
- ☐ anxiety/ panic/ panic attacks
- ☐ obsessive compulsive symptoms
- ☐ mood swings
- ☐ impaired concentration & memory difficulties with decision making
- ☐ social isolation
- ☐ sleep disturbance
- ☐ decreased self esteem
- ☐ self harm behaviors
- ☐ drug use and abuse
- ☐ alcohol use and abuse
- ☐ shoplifting
- ☐ excessive shopping
- ☐ risky sexual behaviors
- ☐ poor impulse control
- ☐ anger/ irritability
- ☐ family conflict/relationship struggles
- ☐ other: _____

Is there any other information you would like me to know?